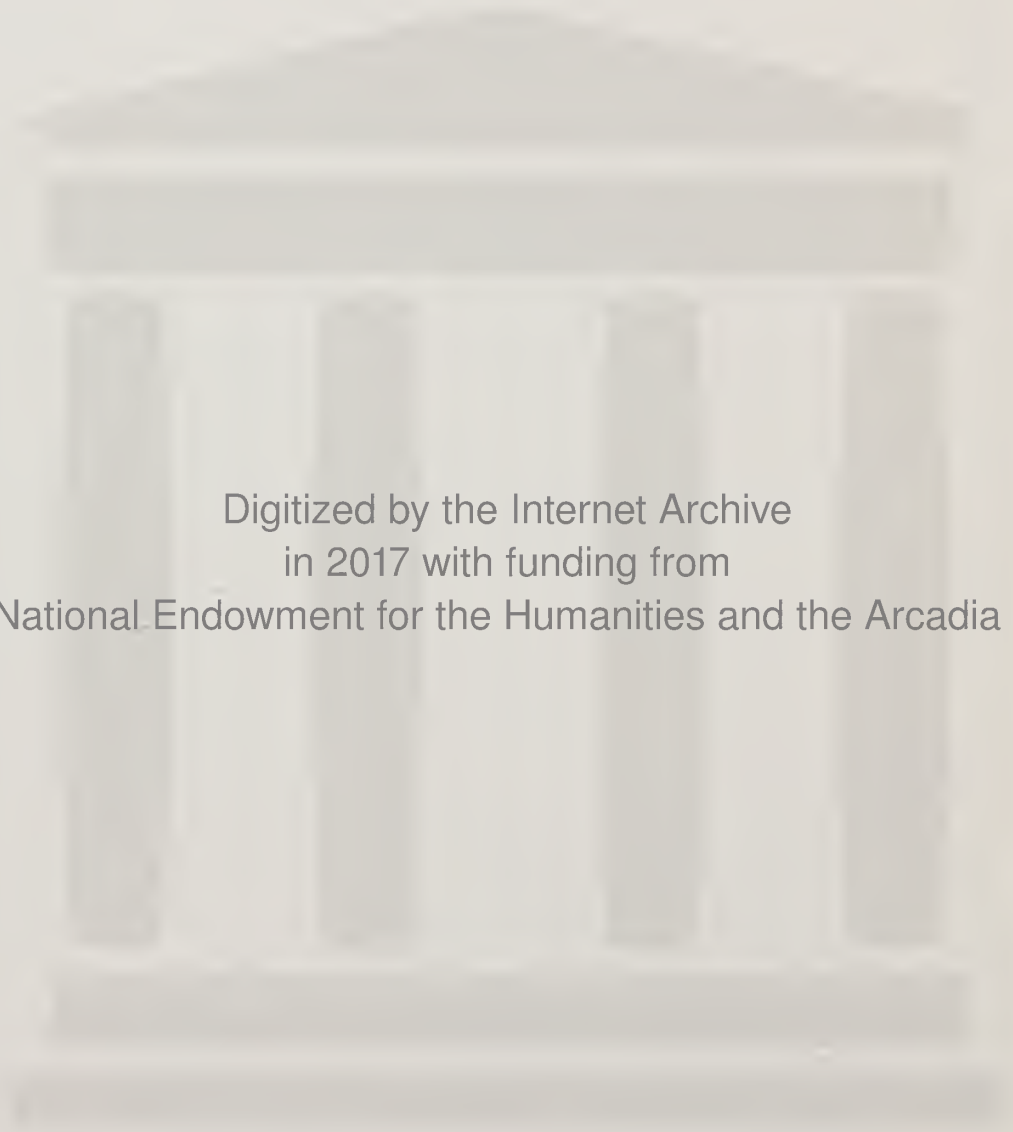
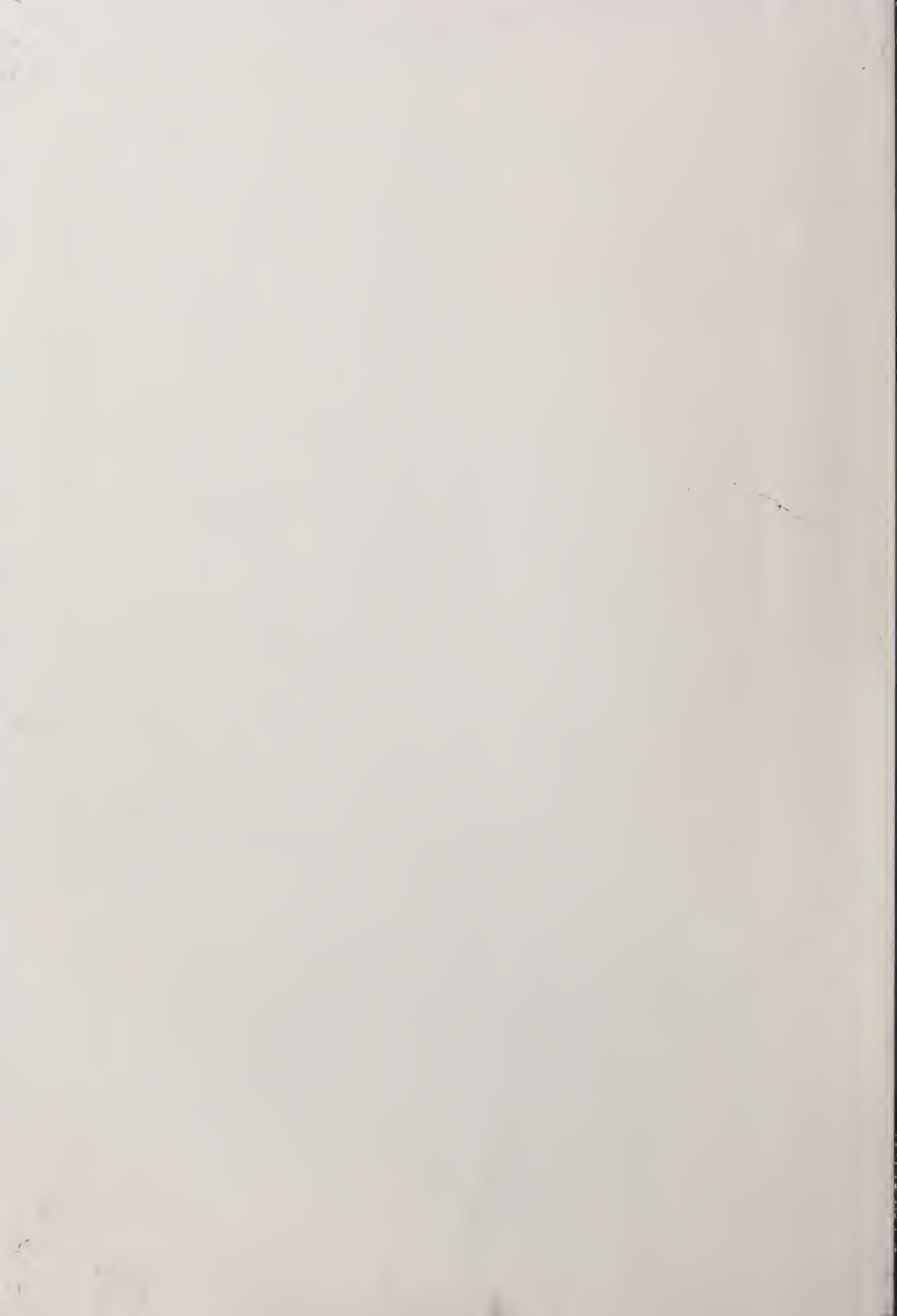




Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

FALK LIBRARY OF THE HEALTH SCIENCES

SEP 04 1997



Minnesota Medicine

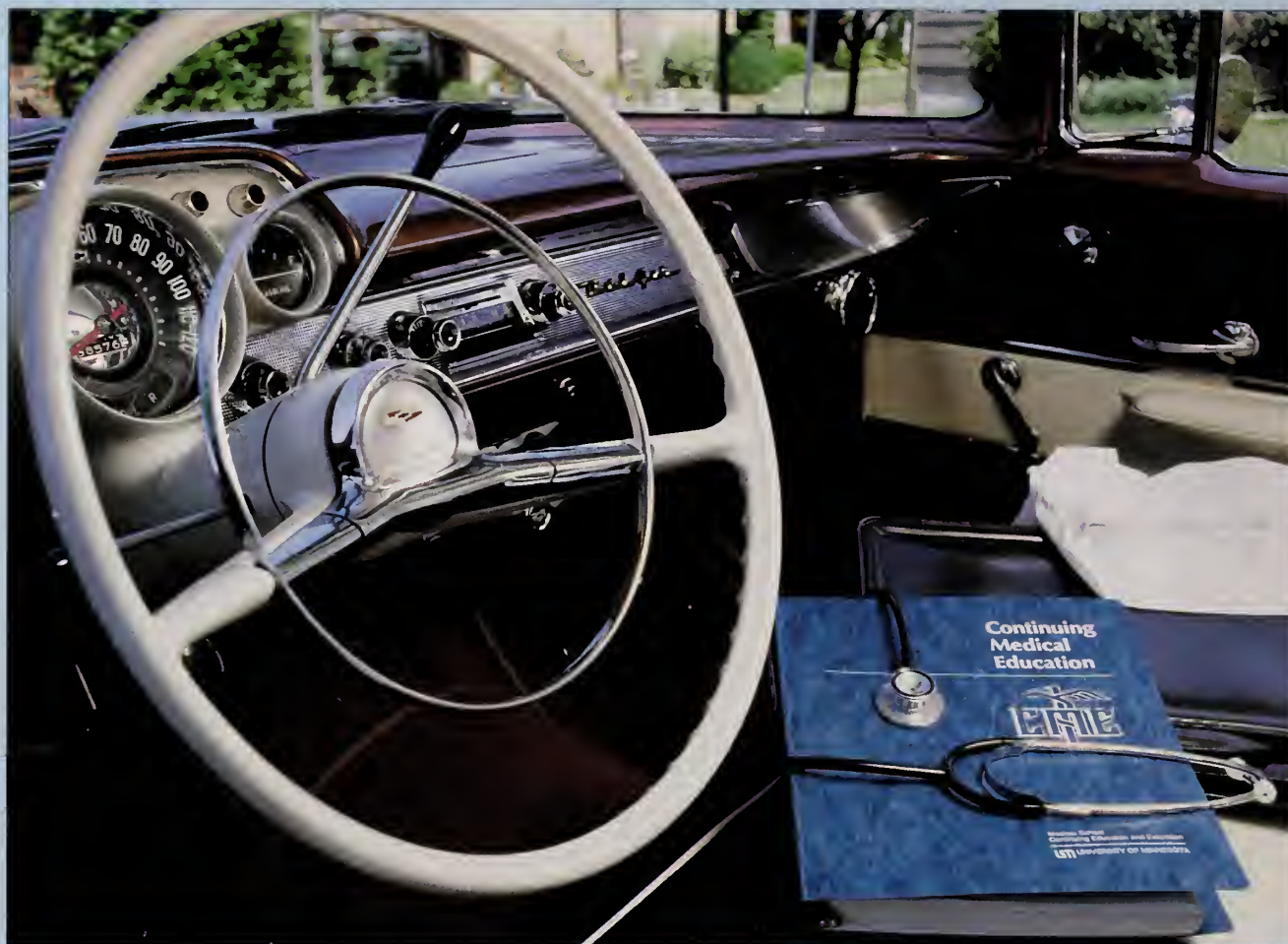
A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession, PA 15261-0001
Pittsburgh, PA 15261-0001

MAA's Journal is the
Quality & Coverage Act

JANUARY 1995

Where knowledge and practice interact



CONTINUING MEDICAL EDUCATION

Continuing Education and Extension, University of Minnesota
Selected Courses, Winter-Spring 1995

**Neuroimaging at
Turnberry Isle**
February 8-12 • Aventura,
FL

**Geriatric Drug Therapy
Symposium**
February 22-23 •
Minneapolis

**Prevention and
Management of
Atherosclerotic Disease**
February 24 • Minneapolis

Medical Update 95
March 6-10 • Ft.
Lauderdale, FL

**Third Annual Conference:
Brain to Pelvis 1995**
March 19-24 • Beaver
Creek, CO

**HIV Primary Care
Conference**
March 24 • Bloomington

**Health Care Reform and
the Academic Health
Center**
March 30 • St. Paul

**Common Cardiac
Arrhythmias: Recognition
and Treatment Principles
for Internists and Family
Physicians**
April 21 • Minneapolis

**Allergy and Clinical
Immunology**
April 28 • Minneapolis

**Family Practice Review &
Update**
May 1-5 • Minneapolis

**Annual Ophthalmology
Course: The Eye of the
Child**
May 5-6 • Minneapolis

**Women's Cancer Center
Program: Gynecology &
Gynecologic Oncology**
May 9 • Minneapolis

**Current Concepts in
Radiation Therapy**
May 10-12 • Minneapolis

**Vascular Diseases
Symposium**
May 20-21 • Plymouth, MN

**Advanced and
Introductory Workshops
in Clinical Hypnosis**
June 1-3 • St. Paul

**Topics and Advances in
Pediatrics**
June 14-16 • Minneapolis

**Advances in Breast and
Cancer Surgery**
June 26-28 • Minneapolis

Continuing Medical Education, Medical School, Continuing Education & Extension, Radisson Hotel Metrodome, Suite 107,
615 Washington Avenue S.E., Minneapolis, MN 55414; (612) 626-7600

The University of Minnesota is an equal opportunity educator and employer

JAN 19 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER
Design by Michael May.

DEPARTMENTS

- 2 LETTERS TO THE EDITOR
- 5 EDITOR'S NOTEBOOK
- 18 AUTHOR INSTRUCTIONS
- 50 NEWS CLIPS
- 57 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

- 6 CRITICAL CARE FOR THE HEALTH SYSTEM** Fran Miller Toubin
New Board Chair Timothy J. Crimmins, M.D., is working on the MMA's treatment plan for the state's ailing health care delivery system.

PERSPECTIVES

- 8 RECOLLECTION** Phebe Saunders Haugen
Alzheimer's steals its victims' memories and vision of the future, leaving them trapped in a dimly lit space between the past and the present.

COVER STORY

- 10 MMA INTRODUCES THE MINNESOTA HEALTH CARE QUALITY AND COVERAGE ACT** Dave Renner
The Minnesota Medical Association is bringing a bill to the 1995 Legislature in an attempt to refocus health system reform in our state.

EDITORIAL

- 16 MINNESOTACARE: ROUND 4** Sen. Sheila Kiscaden
Key health reform leaders have left office, and the political pressure for reform has waned, but this legislator believes reform efforts will continue much as in previous years.

CLINICAL AND HEALTH AFFAIRS

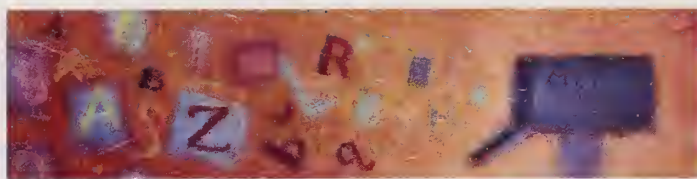
- 19 THE PERILS OF PROZAC** Deane C. Manolis, M.D.
- 25 DEMENTIA AND ALZHEIMER'S DISEASE: INDICATIONS, DIAGNOSIS, AND TREATMENT** Richard Golden, M.D.

MEDICINE LAW & POLICY

- 43 THE BOARD OF MEDICAL PRACTICE IMPROVES ITS COMPLAINT HANDLING SYSTEM** Kent G. Harbison, J.D.
With complaints to the BMP increasing dramatically in recent years, the board has developed a triage system to eliminate frivolous complaints and to reduce its backlog.

33 *The* Monitor

HIGHLIGHTS MMA Board makes key decision on Quality and Coverage Act • Highlights of AMA Meeting • MMA adopts data policy



Child Abuse Article Missed Important Resource

Thank you for bringing domestic abuse intervention before the medical community in your October issue of *Minnesota Medicine*. The article on child abuse (page 15) listed a number of resources that provide both evaluation and training for physicians. The First Witness Child Abuse Resource Center in Duluth, Minnesota, was not included in the list. This community-based program demonstrates clearly how physicians can be part of a multidisciplinary team effort to address the local and regional problem of child abuse. When there is a report of child physical or sexual abuse in our area, the mandatory reporting agency—either social services or the police department—interviews the child on video. A trained investigator, who most likely was trained at a Corner House Program in Minneapolis, conducts the interview. If appropriate, the child is referred to a physician who has received special training in child abuse.

The First Witness Child Abuse Resource Center houses training programs for law enforcement personnel, attorneys, judges, and social workers. These week-long courses are offered six times a year. A series of half-day programs also educates health care professionals on intervening in child sexual abuse and working with the system.

The Duluth Domestic Abuse Intervention Project (highlighted in the October cover story) is an excellent example of how a broad-

based community program can have an impact locally and beyond by serving as a theoretical and practical model for addressing domestic violence. We hope the First Witness Child Abuse Resource Center will similarly address the problem of child abuse.

*Kathryn C. Halverson, M.D.
Family Practice Physician
Duluth Clinic-Lakeside
Duluth, Minnesota*

Thanks PPAC Volunteers!

We want to recognize a group of volunteer physicians and nurses who devoted every other Tuesday afternoon from May 17 through August 23 to evaluating practice guidelines for unstable angina.

The Practice Parameter Advisory Committee (PPAC) of the Minnesota Health Care Commission assembled a volunteer group of experts to review practice guidelines. The charge to each panel was to review and recommend or reject guidelines. The expert panel's recommendations on unstable angina have been delivered to the PPAC.

These volunteers accepted their small compensation—a cup of coffee and a doughnut—and, in fact, gave up income by vacating their practices for eight Tuesday afternoons. They also did independent research and study between meetings. They commuted up to several hours each way to the meetings with no travel reimbursement. The dedication and qualification of these volunteers is notable.

The general public, the Minnesota commissioner of health, and the medical profession owe these

11 individuals a huge thank you: Gregory Angstman, M.D., R. Morton Bolman, M.D., Catherine Borbas, Ph.D., Mark Bixby, M.D., David Cheesebrow, R.N., David Goldstein, M.D., Carl Heltne, M.D., Steven Hillson, M.D., Stephen Kopecky, M.D., William Northrup, M.D., and Barbara Unger, R.N.

Many thanks to these individuals.

*Richard Sturgeon, M.D.
Abbott Northwestern PHO
Minneapolis, Minnesota*

*Gordon Mosser, M.D.
Executive Director
Institute for Clinical Systems
Integration
Minneapolis, Minnesota*

Single-Payer System Would Allow More Family Time

The September issue of *Minnesota Medicine*, which included articles on the single-payer system, was particularly interesting to me as a rural physician in a primary care specialty. Over the years, my family has made numerous sacrifices because of the nature of my practice as well as community and hospital demands—much to the detriment of a pleasant lifestyle. I would welcome a single-payer system. I could work a schedule much like anyone else in a normal routine job. This would allow me more time for my family and for activities I enjoy. Also, I would not be responsible for nuisance calls from the hospital and other services who feel they "own" me.

Unfortunately, the quality of

care in our area would diminish significantly under a single-payer system because there just wouldn't be enough manpower to take care of patients' needs; as in most rural areas of the state, we are short-handed. However, my lifestyle would measurably improve.

Also, if I were working an eight-hour day, I could participate in collective bargaining for wages, salaries, and benefits. I would probably get a better return on my time than is possible with some of our third-party payers, such as Medicaid, and some of the HMO capitated plans.

G.F. Kishel, M.D.
Department of Pediatrics
East Range Clinics, Ltd.
Virginia, Minnesota

Hospitals Can Take Steps to Ease End-of-Life Decision Making

Many hospitals and medical centers around the state are wrestling with issues related to death and dying—a hot topic in the media today. To help address these issues, I propose that hospitals carry out three tasks: 1) Establish a supportive environment for patients to prepare living wills and durable power of attorney documents; 2) Set up an ethics committee composed of health care personnel and lay people; and 3) Make hospice-type care available.

These three actions can all be completed within a relatively short time span, perhaps one to two years.

While working toward these goals, we also achieve the following: 1) We send a clear message to our communities that health care personnel take these issues serious-

ly and intend to lead a dialogue to increase awareness of them; 2) We help hospitals to comply with the Patient Self-Determination Act; 3) We expand and improve physicians' care of and interaction with patients, especially dying patients; 4) We help physicians work with their hospitals in treating severely ill patients; 5) We enhance the communication among various departments regarding difficult situations related to death and dying; and 6) We more readily handle the complicated issue of pain management and control.

Taking these steps will help us to deal with such issues as cost, nursing home beds, and insurance programs. Even if a hospital does not become an accredited hospice provider, the establishment of one or two rooms within the hospital that can function as a hospice unit will greatly help patients, families, and hospital staff in dealing with difficult issues surrounding death.

The three actions might seem like an immense amount of work, time, and effort, but this is not the case. Wonderful resources are available to help hospitals accomplish these tasks. A network of ethics committees around the state exists, so there is no need to re-create the wheel. Major hospital networks have created hospice units, and these facilities frequently are interested in helping smaller hospitals initiate similar programs. Living wills and durable power of attorney documents are widely available, as are speakers who can provide background information and assistance.

Establishing hospice-like units,

LETTERS continued on page 48

Correction

The November *Minnesota Medicine* cover story, "Taking the Pulse of Medical Technology," contained a photograph of Richard DeWall and a helical reservoir bubble oxygenator. The description accompanying the photograph named DeWall as the inventor, when, in fact, DeWall is a co-inventor of the device—along with C. Walton Lillehei, M.D.

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Internal Medicine
Pediatrics**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profitsharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

M MULTICARE • ASSOCIATES
OF • THE • TWIN • CITIES

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Kristi Belcamino

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Frank A. Bures, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuhen Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Ophelia Balcos

Board of Trustees

N.W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tomhers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
E. Delores Durr, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legal Affairs
Mary E. Prentnieks, J.D.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

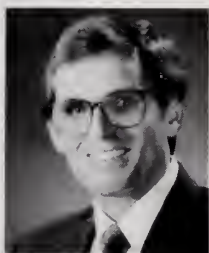
Applying the Healing Arts to Health System Reform

Charles R. Meyer, M.D.

Whose job is it to craft health system reform? In 1992, the Minnesota Legislature, directed by the "Gang of Seven," designed the state's first reform legislation, HealthRight. The 1993 fashion was federal, with Clinton's Health Security Act. But it's the end of 1994, and Bill has demoted his connubial health system architect, and the Republicans control Congress. In 1995, "painter's block" may reduce Congress to doodling on health care reform, with Newt and Co. doing the drawing.

Traditional politics might suggest that the states will need to push further changes. In 1994, while the U.S. Congress dawdled, Minnesota legislators dabbled, making modifications to the retitled MinnesotaCare but avoiding such treacherous issues as program funding and final achievement of universal coverage. As 1995 opens, the final shape and sticker price of the production are unknown. Will it be a work of beauty and symmetry affordable by the masses? Or will it emerge as an intricate mélange with an inflated price tag?

Where is organized medicine through all of this? Will it simply react to government's moves? Or will it create its own design for reform? This month's *Minnesota Medicine* describes the Minnesota Medical Association's current foray into legislation sculpting. Our cover story outlines the evolution, rationale, and substance of the MMA's proposed health system reform legislation, the Minnesota Health Care Quality and Coverage Act. Our Face to Face profile features the new MMA chair, Timothy Crimmins, M.D., who has been in the thick of the drafting process. And Sen. Sheila Kiscaden's editorial, "MinnesotaCare: Round 4,"



"With the Quality and Coverage Act, organized medicine is creating rather than reacting."

describes the health care mood of the Legislature as the 1995 session approaches.

For those of you already yawning at the mention of legislation, I provide the following small snapshot of the proposed bill, which is intended not to do away with reform but to correct deficiencies the MMA sees in the current MinnesotaCare legislation.

1. Affordability: Don't create new widgets (RAPO) to solve problems that can be fixed by modifying existing tools. Standardize health plans and rationalize professional liability law, but don't add another convolution to the bureaucratic snarl.

2. Quality: Make the managed care system user-friendly—let patients choose providers freely, based on good information. Let providers feel comfortable with the validity of how their practice is being measured, and let all participants know that the push for quality is not just disguised cost control.

3. Universal coverage: Cover everyone, mean it, pay for it with fair funding, and close loopholes that allow some plans to avoid covering sick people.

The MMA's Quality and Coverage Act may not be perfect. Its reliance on competition and the free market to curb costs can be challenged as an old trick that hasn't worked. Its recommended employer pools to replace RAPO are untested. But as Lynn Blewett of the Minnesota Department of Health wrote in the fall 1994 *Health Affairs*, "Reform is an iterative process." Although listening to some legislators speak might belie this, "iterative" here does not imply meaningless repetition. In this case, iteration is used as it is in fractals, designs formed by repeated drawing of curves. Like fractals, iteration in reform means making something attractive by building on the previous image. With the Quality and Coverage Act, the MMA is adding its lines and curves to the picture. It is organized medicine creating rather than reacting.

With Dr. Deane Manolis' article on Prozac in this issue, I was tempted to suggest 20mg daily prior to discussing health system reform. But the outlook is not that depressing. If we all strive for a fair, simple, and user-friendly system that offers universal coverage and preserves quality, the health care fractal will grow gradually but beautifully.

MMA

Critical Care for the Health System

New Board Chair
Timothy J. Crimmins,
M.D., is working on the
MMA's treatment plan for
the state's ailing health
care delivery system.

.....
By Fran Miller Toubin

In many ways, spearheading the drafting of a health system reform bill for Minnesota is similar to what Dr. Timothy J. Crimmins does every day as an emergency physician at Hennepin County Medical Center: he must quickly gather as much information as possible to make an accurate diagnosis, assess the consequences of various therapeutic options, and, finally, decide on a course of treatment that will, at best, be a complete cure and, at least, alleviate pain and suffering. And he must make these decisions with the patient's best interest in mind.

As incoming chair of the Minnesota Medical Association's Board of Trustees, Crimmins is guiding the MMA's development of health system reform legislation to bring before the state Legislature this session—a tough case that will test his medical and political know-how. This time, the patient is the health care delivery system, which Crimmins believes must be redirected fast, before quality suffers.

"Cost containment can't be the only goal of reform—the risk is very real that we'll see a decrease in the quality of medical care, and patients may begin to suffer," warns Crimmins. "Today, our inpatient hospital rates are way down; people are being sent home 'quicker and sicker.' I don't know how much further we can go to reduce hospitalization," he says. "For now, though, we're holding the line on quality of care. In Minnesota, we still have excellent hospital care outcomes. And we have good immunization rates and excellent infant mortality and life expectancy rates."

Crafting legislation that reshapes the current system into one that is more rational, equitable, affordable, and accountable—one that is physician-friendly, good for the public, and represents sound public policy is no easy task. "Bill Clinton couldn't do it; Hillary Clinton couldn't do it; George Mitchell couldn't do it; Dave Durenberger couldn't do it ... " says Crimmins wryly. "The bottom line is that maybe it can't be solved at the national level, and a state solution is more appropriate."

Some of those Beltway politicians might do well to take a lesson from Crimmins, a native of Indiana, who knows his way around Minnesota public policy issues as well as he knows the Hennepin ER. Holding a B.A. in chemistry from the University of North Carolina at Chapel Hill, Crimmins graduated Alpha Omega Alpha from Indiana University School of Medicine. He has been involved with the MMA almost from the time he arrived in Minneapolis, becoming active on various committees and eventually chairing the Committee on Ethics and Medical-Legal Affairs.

He also has served on the board of directors of the Minnesota Safety Council, as president of the Minnesota Seat Belt Coalition, and as chair of the Governor's Transportation Safety Advisory Commission. Besides his practice as a board-certified emergency physician with Hennepin Faculty Associates, Crimmins is medical director of the Occupational Medicine Clinic at Hennepin County



"There is enormous potential for physicians and for the future of health care in this state if we can speak in a uniform voice."

—TIMOTHY J. CRIMMINS, M.D.

Medical Center and medical director of emergency medical services for the city of Edina, where he lives with his wife, Sharon Marx, a physician specializing in geriatrics, their 11-year-old daughter, Erin, and their 9-year-old son, Ryan.

Crimmins, whose area of interest is public policy, says the whole idea of giving back to the community and healing the sick was instilled in him during his parochial school years in Indiana. Although he initially chose oncology as his specialty after several relatives died of cancer, he says the ER is better suited to his personality. The only thing he misses in the exciting, diverse, fast-paced world of emergency medicine is the continuity of care and patient follow-up. "I never see my patients again," he laments.

Crimmins brings a wealth of experience and diplomacy to the formidable legislative challenge that marks the beginning of his three-year term as MMA board chair. He is sympathetic and empathetic to the frustrations and anger of many physicians he represents, sensitive to their desire for fair compensation, greater access to outcomes-based data, more autonomy, and control of their own work processes. However, because he remains focused on patient interests above all else, his mission is clear whether he's in the ER or in the MMA boardroom.

This clarity of purpose, along with his political know-how, may help Crimmins and the MMA legislation succeed where others have failed. "We're consulting as many people as possible to try to assess the medical, legal, economic, and political consequences of our words and actions. And, we're building coalitions," says Crimmins. "In Minnesota, the players have been willing to sit down and talk, despite the fact that they come to the table with different agendas and vested interests. Minnesota physicians have endured considerable turmoil resulting from the reform initiatives. I think physicians are now in a position to say, 'This is the health care model that will work.'"

The model that Crimmins and the trustees are promoting, the Minnesota Health Care Quality and Coverage Act (see cover story, page 10), supports the basic tenets of MinnesotaCare, such as universal coverage and the development of a basic set of health care benefits for everyone. However, it seeks to achieve universal coverage through market reforms and favors broad-based funding sources. The board supports heavy taxation on tobacco—with the added goal of reducing its consumption—and a tax on alcohol. It also calls for a repeal of the regulated all-payer option, the 2 percent provider tax ("Do we tax grocers to pay for food shelves, realtors to pay for subsidized housing, or lawyers to pay for legal aid?" asks Crimmins), and addresses concerns that physicians have about data management and quality assurance. The proposed legislation is based on a competitive model that allows patients to choose health plans and physicians, and promotes copays and deductibles to make patients more aware of the cost of services.

It encourages employers to offer group insurance rates, multiple health plan options to their employees, and to bear some of the burden for the costs of

CRIMMINS continued on page 30

My father used to say with amusement and a touch of awe that my mother could remember six digits of every phone num-

ber she had ever known in her life. "Of course," he would add, in case we had missed the point, "without that seventh digit, it is not a very useful talent." My mother, on the other hand, always said of him that there seemed to be no one in the Twin Cities whom Dad didn't know, and more amazing still, he remembered everybody.

It began, innocuously and insidiously enough, with scarcely more than a momentary inability to recall the name that went with an old familiar face. Before long, we were routinely whispering the names of old acquaintances to him in social situations in which it would have embarrassed him to appear forgetful. He had had so many patients over the years, after all, and they were all special in one way or another. How could he forget their names?

In time, there was the phone book problem. "I need to have my glasses checked," he'd say. "Look up that number for me, will you?"

In truth, the dizzying array of numbers, aligned in those orderly columns, was confounding and maddening. And then there was the trip

to Switzerland for the wedding of a granddaughter. What should have been an exhilarating adventure was instead a terrifying descent into unfamiliarity, panic, and loss. He wanted so desperately to get away from strange cars on foreign streets and from seas of strangers speaking in gibberish. He longed to go home, but he could no longer find the way.

Like all victims of Alzheimer's disease, my father was losing his ability to learn, to draw meaning from new experience, and for a brief, excruciating time, he knew it. What he couldn't fully realize was the equally devastating loss of his own story, which was slipping away, along with his memory. For it is

the theft of memory that, as one writer put it, is the cardinal devastation of the illness.

Memory, that strange and wonderful gift, connects us to every person and place we know and to our own past. It enables us to get through life, day to day, minute to minute, and if we're



ILLUSTRATION BY KRISTINA SWARNER

Recollection

Alzheimer's steals its victims' memories and vision of the future, leaving them trapped in a dimly lit space between the past and the present.

By Phebe Saunders Haugen

lucky, to piece it together at the end. It allows us to find our way home, to recognize those we love, and to possess our own histories. Each day, our experience adds to the store of accumulated treasures we can summon to cheer us, or to make us weep, or to remind us how far we've come. When Alzheimer's disease strikes, it not only robs its victims of the ability to add to that store, but it steals the larder itself, the decades of experience that make up so much of who we are. It leaves its sufferers trapped in a dimly lit space between the past and the present, unable to make sense of either one, unable to visualize a future.

For a time, my dad clearly knew that my mother, my brother, and my sisters and I belonged to him, but he fairly quickly became unable to say which one of us was which. We watched him in his early nursing home days in the dining room, ever the consummate host, graciously inviting the other residents to have some food and a drink, and thanking them for coming to what seemed to him a fine party. We listened as he haltingly described some minuscule event from his Navy days, as if it were happening to him all over again, nearly 60 years later—a particularly deceitful trick Alzheimer's disease plays on memory.

Like my father, we his family are caught between the past and the present, wanting to remember the kind, intelligent, forceful man, who with true Scandinavian grace never looked anything close to his age—the omnipotent physician whom medicine can neither cure, nor really even help much, as yet. Like all families in such a situation, we feel powerless and overwhelmed at both his loss and our own.

Nothing can give back what our loved ones with Alzheimer's disease have lost. Memory and the capacity to add to it, once stolen by the illness, can never be returned to our fathers, our mothers, our spouses, our siblings. Yet, ironically

enough, it is memory alone that can restore those much loved persons to us; for in remembering them, we put them back together, whole, healthy, well.

And so, while we wait and work for the eventual medical treatment that will really help the victims of this most predatory of illnesses, we can remember them; we can hope for that occasional vivid dream of earlier, stronger days, the kind of dream from which we awaken with a photograph of Technicolor clarity, to displace, for at least a while, the images of diminishment and loss that fill the last months and years.

And we can stand by them, we can remember for them, and we can tell a little of their story to whomever will listen. **MM**

“Memory, that
strange and
wonderful gift,
connects us to
every person and
place we know and
to our own past.”

Phebe Saunders Haugen is a professor of law specializing in biomedical ethics at William Mitchell College of Law. She read this paper at the 1991 Lasting Memories Benefit Ball for the National Alzheimer's Association (Minnesota Chapter).

John A. Haugen, M.D., died December 11 at the age of 88. He was a member of the 1930 graduating class of the University of Minnesota Medical School. After several years in general medicine, he took his residency in obstetrics and gynecology at Detroit Receiving and Chicago Lying-In hospitals. During World War II, he served as a Lieutenant Commander in the Medical Corps of the U.S. Naval Reserve, stationed with Marine Aviation in the South Pacific. He returned to the Twin Cities after the war and continued to practice obstetrics and gynecology at Abbott Hospital for more than 30 years, until his retirement in 1975.

MMA Introduces

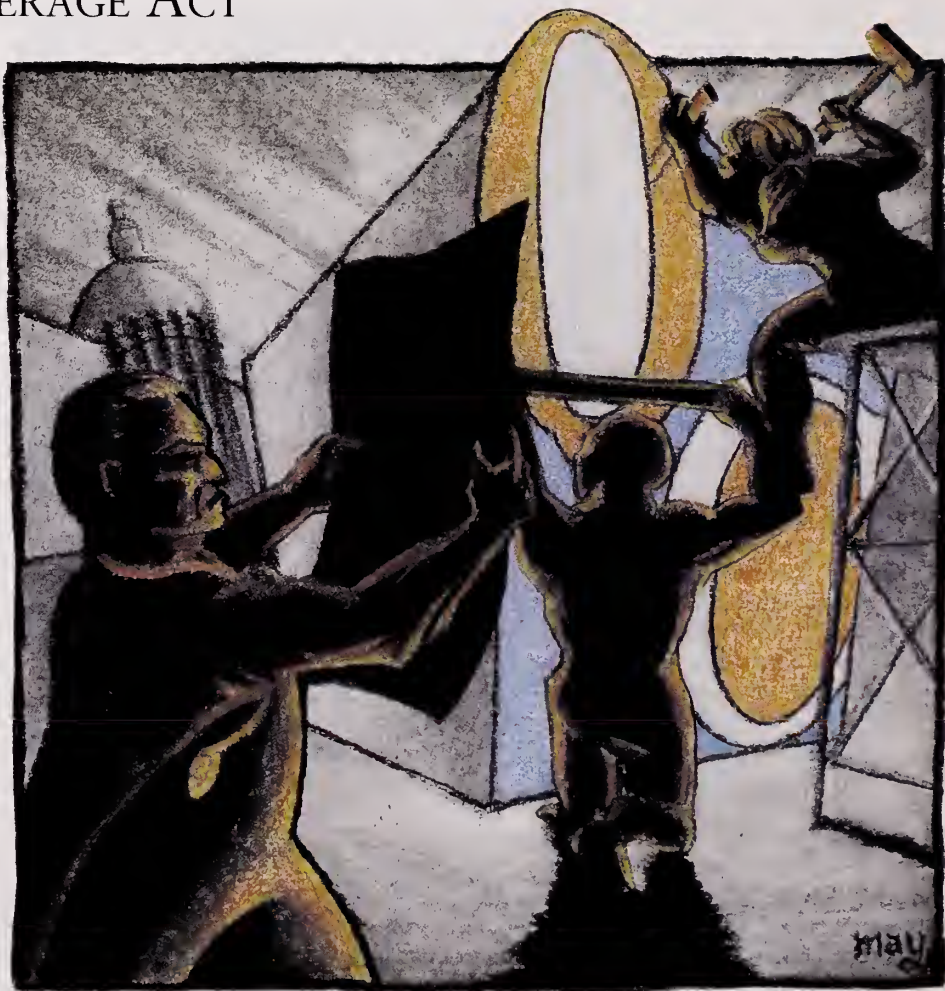
THE MINNESOTA HEALTH CARE QUALITY AND COVERAGE ACT

The Minnesota Medical Association is devising its own treatment plan for the state's improving but still ailing health care delivery system. Spurred by overwhelming support at the September Annual Meeting, the MMA will intro-

duce a comprehensive bill called the Minnesota Health Care Quality and Coverage Act this legislative session. The bill is intended to reaffirm the MMA's Principles for Health Care Access and Reform adopted in 1991 and to correct deficiencies the MMA sees in the current MinnesotaCare legislation.

By Dave Renner

Passage of the bill is the MMA's top priority this legislative session.



ILLUSTRATIONS BY MICHAEL MAY

History of Health Reform and MMA Involvement

Minnesota has been in the throes of health system reform since the late 1980s. In 1989, the Health Care Access Commission was created to study and recommend reforms to expand access to health care. Two years later, the Legislature passed and the governor subsequently vetoed a bill called House File 2 that was designed to provide subsidized coverage to uninsured Minnesotans with incomes below 275 percent of the federal poverty level.

In 1992, the infamous "Gang of Seven" developed the sweeping HealthRight reform legislation that was signed into law. This legislation, later renamed MinnesotaCare, was drafted after months of meetings among the seven legislators, who were from both the DFL and IR parties. This legislation has since been modified each year in response to Minnesota's rapidly changing health care market.

The Minnesota Medical Association has been in the middle of these reforms, supporting legislation that promotes cost-effective, quality care while preserving patient choice and appropriate levels of physician autonomy. The MMA strongly opposed the passage of HealthRight in 1992 because it created mandatory health care spending limits and the 2 percent provider tax. In 1993, the MMA successfully lobbied for inclusion of antitrust protection that is now viewed as a model for other states. And last year, the MMA was instrumental in delaying the implementation of integrated service networks (ISNs) to allow for the establishment of locally controlled community ISNs and was a major force in modifying the regulated all-payer option (RAPO), ensuring that it will be a legitimate option for providers.

The role of patient advocate is one that the MMA's members take very seriously. The MMA has always been committed to supporting policies that are best for the patient, and the association has made quality patient care a priority as it developed and promoted legislation over the last five years.

However, health system reform is extremely complex. The bills it

generates are lengthy and confusing, making it difficult at times for the MMA to promote its principles effectively. Policymakers want to know whether we support or oppose a given bill—thumbs up or thumbs down. This makes it difficult for us to explain the parts of a bill we support and the parts we don't. Consequently, the MMA's position at times has been confusing to policymakers and even to our own members, and has often been misconstrued.

"A major goal of the Quality and Coverage Act is securing appropriate, adequate funding sources for health system reform."

In an effort to promote and clarify the MMA's position on health system reform, the 1994 House of Delegates of the MMA adopted a resolution calling for the development and introduction of a health system reform bill for the 1995 legislative session. Resolution 26, adopted unanimously by the House of Delegates, instructs the MMA to reaffirm its Principles for Health Care Access and Reform, adopted in 1991 (see sidebar, page 12), and to develop legislation that addresses the broad issues of "improved patient care, minimization of bureaucracy, decreased costs, and an environment in which physicians can deliver quality patient care."



Why an MMA Bill This Year?

Why the overwhelming support this year for the MMA to draft its own piece of legislation? All the reasons are not known, but speculation suggests several possibilities: some members probably saw this as an opportunity to promote a single-payer agenda; others probably saw it as an opportunity to repeal MinnesotaCare and undo all the reforms that have been adopted over the last five years; however, like the MMA Board of Trustees and officers, most members proba-

bly saw it as an opportunity to develop a package of reforms that a majority of physicians can support and that will significantly improve our health care system.

The House of Delegates adopted Resolution 26 on September 30, 1994. Three weeks later, on October 22, the MMA Board of Trustees held a special meeting to begin developing a bill. Very early during that meeting, the board concluded that the MMA could not, and did not want to, throw out health system reform altogether. The board realized that most of the turmoil occurring in health care delivery is not the result of MinnesotaCare; rather, the marketplace is driving much of the change. Simply repealing MinnesotaCare will not stop the restructuring.

The board also realized that the legislation passed in 1992 was designed to reform a health care system markedly different from today's. In 1992, health care

inflation was at 15 percent to 20 percent and had been for a number of years, many parts of the state had no organized health care system, and most payers and providers faced little accountability for the cost or quality of care.

Many of these problems no longer exist today. Health care costs have stabilized, with single-digit increases; networks and systems are being developed in parts of the state no one ever expected; and purchasers are demanding far more accountability from health plans and providers. Reform is moving in the right direction. However, this does not mean that further reforms are not needed. Much like patient care, for which treatment plans must be modified as the symptoms improve, health system reform must be modified as the marketplace is transformed.

MMA Principles for Health Care Access and Reform

In 1991, the Minnesota Medical Association Board of Trustees adopted a position paper setting forth eight principles on which to base health system reform and listed specific provisions to be included in any state plan. This position paper, "Health Care Access and Reform," was reaffirmed by the MMA House of Delegates in amended Resolution 26 and has served as a basis for the MMA-drafted bill to be proposed in 1995. The eight principles and key strategies to support them are listed below.

1. All Minnesotans are entitled to a basic level of health care.

2. Individuals, employers, and the government all have an obligation to ensure adequate coverage of all citizens.

- Require every citizen to have coverage for basic health care.

- Require any health plan, public or private, to use the MMA Medical Benefits Task Force report as the model for providing a basic level of care.

- Emphasize primary and preventive services.

- Use mechanisms such as co-pays, deductibles, and prior authorization to encourage the proper use of health care services.

- Provide state assistance on a sliding scale to those who cannot afford health coverage.

- Give employers incentives to offer basic coverage to employees and their dependents.

- Give individuals tax incentives to buy basic health coverage.

3. Reforms must be implemented to improve the effectiveness and quality of care.

- Involve professional medical organizations in coordinating and disseminating practice parameters.

- Base data initiatives on scientifically valid research and analysis.

- Use peer review for educational purposes.

4. Insurance must be portable for individuals changing jobs or moving to other parts of the state.

- Establish premium rates for individuals and small groups on a carrier-specific, statewide community-rated basis to allow risk to be spread among all insured people.

- Prohibit pre-existing condition clauses or denial of coverage on the basis of health status.

- Allow health plans to use reinsurance mechanisms in order to share risk.

5. Cost containment must be achieved while maintaining a high-quality delivery system

- Cut administrative costs by using standardized claim forms, billing procedures, and utilization review criteria.

- Review issues and costs related to technology.

- Develop a system to facilitate the appropriate, cost-effective use of prescription drugs.

- Maintain a multi-payer system to preserve patient choice.

The Minnesota Health Care Quality and Coverage Act

The Minnesota Health Care Quality and Coverage Act has three main goals:

- Remove the requirement that all health care be provided through either ISNs/CISNs or RAPO, and promote reforms that will allow for multiple, accountable health plans whose products can be compared based on quality and cost.

- Eventually adopt funding sources that are broad-based and do not create insurmountable administrative problems. The existing 2 percent provider tax is too narrowly based, difficult to administer, and raises insufficient funds.

- Address the health care costs caused by the current tort system.

- Address the antitrust implications for health care facilities of sharing services.

6. Geographic access must be assured throughout the state of Minnesota.

- Develop programs to help communities recruit and retain health professionals.

- Help communities develop local plans to assure continued geographic access to care.

7. Public education and health promotion efforts must be expanded

- Increase efforts to achieve a smoke-free society by the year 2000.

- Increase funding for health promotion and disease prevention.

- Develop an educational campaign on the appropriate use of the health care system.

8. An adequate broad-based funding source must be dedicated to ensuring universal coverage.

- Because the health care access problem demands a societal solution, funding must come from many sources. Funding should be raised from each of the following sources and dedicated to assuring access to health care for all Minnesotans: tobacco taxes, alcohol taxes, and income taxes. A payroll tax on employers with credits for employers subsidizing health coverage should also be promoted.

- Adopt reforms that do not conflict with the ultimate goal of universal coverage. Although it may not be achieved this year, the state needs to continue with reforms that eventually will lead to universal coverage.

Multiple, accountable plans

Under Minnesota's existing health reform law, by July 1, 1997, all health care would be provided and paid for either within a managed care entity (an ISN or a CISN) or through a state-developed, regulated fee schedule, (the regulated all-payer option). All other health insurers that

are regulated by the state, such as HMOs, PPOs, or indemnity insurers, would be required to become licensed as ISNs or CISNs. Providers who deliver care to patients who are not enrolled in an ISN or a CISN would be paid according to the state RAPO fee schedule.

Under the model envisioned by the MMA, multiple types of payers would continue to exist—ISNs, CISNs, health care co-ops, HMOs, Blue Cross/Blue Shield, and indemnity insurers.

The regulatory and accountability structures, the reporting requirements, and the benefits requirements for these different health plans would be amended to create plans that allow purchasers of health coverage to compare the plans based on cost and quality rather than on structural or regulatory advantage.

The Quality and Coverage Act also would eliminate the RAPO fee schedule, a relative value scale with a Minnesota-specific conversion factor. The idea of a statewide fee schedule appeals to many policymakers because of the ease it creates in controlling costs. However, implementing a fee schedule for all private, non-ISN, or non-CISN care is nearly impossible, and almost everyone who has examined the issue agrees that it cannot be done fairly or efficiently.

Instead of establishing an artificial price control system like the RAPO fee schedule, the Quality and Coverage Act promotes market forces as the means to control costs. Marketplace changes that have emerged in the last three years are controlling costs without a regulatory system like RAPO, and such forces are likely to work better than government regulation. In today's



marketplace, purchasers are demanding a better product at an affordable price; the state is demanding more accountability from both providers and payers; and the pool of insureds is expanding, with strong incentives for individuals to purchase health coverage.

To advance quality improvement for providers, the Minnesota Health Care Quality and Coverage Act calls for the Minnesota Health Data Institute to maintain its focus on gathering appropriate data to be used for educational initiatives that promote improved quality. The Data Institute was developed two years ago as a public/private partnership between providers, payers, consumers, purchasers, and the state to gather data needed to improve quality. The Quality and Coverage Act provides the Data Institute with the staff and resources necessary to carry out its original goal.

To streamline and better coordinate the state's quality and data initiatives, the Quality and Coverage Act repeals the Practice Parameter Advisory Committee and adds the chair of the Health Technology Advisory Committee to the Data Institute Board of Directors. The PPAC now reports to the commissioner of health, and the HTAC reports to the Minnesota Health Care Commission. Both committees have been reviewing existing treatment practices and are making recommendations regarding practice guidelines.

Funding sources

The second major goal of the Quality and Coverage Act is securing appropriate, adequate funding sources for health system reform. The existing reforms are funded by a 2 percent tax on hospitals, physicians, and other independently practicing providers. In addition, a 1 percent tax on HMOs will become effective January 1, 1996.

Besides not raising enough money to achieve universal coverage, the 2 percent provider tax has proved difficult for physicians and clinics to administer. By law, the tax is on the provider's gross patient revenues but can be passed through to third-party payers, either directly or by increasing fees accordingly. Because the multitude of payers all pay the pass-through differently, and because the pass-through to the growing number of self-funded ERISA plans cannot be enforced, it is unclear exactly what portion of it is being paid.

The MMA believes that the 2 percent provider tax must be repealed and replaced with a broad-based tax dedicated to health care. The MMA promotes this position at every opportunity, but it may not be popular with legislators during the 1995 session. The existing funding mechanism clearly is not workable as a long-term op-

"The Quality and Coverage Act promotes market forces as the means to control costs."

tion, but with public and political demands for less government and less taxes, it is not clear what type of broad-based tax should be adopted. As a minimum, the Quality and Coverage Act is promoting increased tobacco and alcohol taxes because alcohol abuse and smoking increase health care costs.

Universal coverage

The third major goal of the Quality and Coverage Act is to adopt reforms that do not conflict with and continue to move the state toward universal health care coverage. Many of the reforms adopted so far cannot be fully implemented until we achieve universal coverage. This is especially true of the insurance reforms being implemented to prevent insurers from selling policies that encourage the healthy to have coverage while discouraging those with health problems from obtaining coverage. These reforms include severely limiting insurers' ability to use pre-existing condition exclusions within policies, implementing rating bands that prohibit insurers from making a product unaffordable to persons over a certain age or with a particular health condition, and prohibiting the denial of coverage based solely on health status. These reforms cannot be fully implemented until everyone has some form of coverage; otherwise, insurers may not have a large enough base of healthy enrollees to spread risk.

The Quality and Coverage Act recognizes that although universal coverage may not be obtainable this year, the state must continue to pursue policies that will eventually reach the goal. The Quality and Coverage Act supports some form of a "free-rider" penalty, a concept being promoted by the Minnesota Health Care Commission. Under the free-rider penalty concept, anyone who does not have an appropriate level of health care coverage would pay a financial penalty dedicated to health care. Statistics on the uninsured show that a large proportion of the uninsured are young healthy men who have the financial means to purchase health coverage but simply choose not to. The free-rider penalty would be a powerful incentive to purchase coverage.

MMA Member Input

The development of the Minnesota Health Care Quality and Coverage Act is a major undertaking for the MMA. For the bill to be successful, its provisions must be supported by the membership. To develop this bill, the Board of Trustees has held three special meetings, in October, November, and December, and the entire House of Delegates will convene for a special session on Saturday, January 7, 1995, at the Northland Inn in Brooklyn Park. Member input is being solicited at each of these meetings and incorporated into the bill. To gather additional input from the membership, the MMA has brought together five focus groups throughout the state during the last three months. Finally, a membership-wide survey was included with the November *Monitor In Brief* soliciting members' opinions on key elements of the Quality and Coverage Act.

As this article goes to press, the proposed Quality and Coverage Act has not been approved by the MMA House

of Delegates. The House may modify some aspects of the bill at the January 7 meeting but is unlikely to alter the main focus of the bill. Watch upcoming issues of *The Monitor* (published inside *Minnesota Medicine*) and *The Monitor In Brief*, a monthly supplement published through June, for details on the bill's progress.

The bill's success depends on the entire MMA membership. As more information reaches you about the Quality and Coverage Act early in the legislative session, please take the time to read it, and then share it with your legislators. They need to hear from you if we are going to succeed in passing legislation that will improve patient care, minimize bureaucracy, decrease costs, and promote quality patient care.

MM

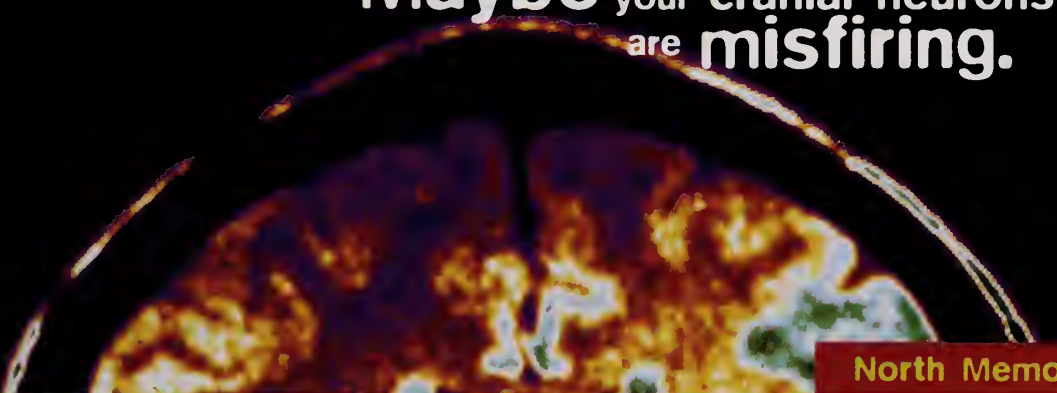
Dave Renner is the Minnesota Medical Association's director of legislation and public policy.

Questions about the MMA's Health Care Quality and Coverage Act can be directed to the MMA's Department of Legislation and Public Policy, 612/378-1875.

Maybe you'd rather have
a **specialist** manage **YOUR** patients.

North Memorial's primary care management philosophy allows you to act as a case manager for all of your patients. And if you're a Family Practice or Internal Medicine Physician, you'd have to have a screw loose to not like the sound of that. To talk to a Physician Placement Coordinator, call 1-800-275-4790.

Maybe your cranial neurons
are **misfiring.**



North Memorial

MinnesotaCare: Round 4

By Sen. Sheila Kiscaden

As the 1995 legislative session approaches, I am reminded of a comment made in 1992 by Robert Waller, M.D., president and CEO of the Mayo Foundation, following the passage of MinnesotaCare. At the time, Waller compared the health care debate to a boxing match and remarked that Minnesota had just finished Round 1 of a 10-round fight over health system reform. Using this analogy, the 1995 session will signify the start of "Round 4" of Minnesota's debate.

This session undoubtedly will bring many complex issues and many heated debates, as has every year of reform. Will we continue to take steps toward universal coverage by 1997? If we do, what are the core "appropriate and necessary medical services" that should be the minimum offered in all health plans? How will we finance the subsidized health



care plan under MinnesotaCare? Will we proceed with the regulated all-payer option? Whatever progress we make, we must keep in mind that we will still be in Round 4—that we will not, and need not, resolve all issues this year.

Although the language is sometimes similar, Minnesota's approach to health system reform is different from what was attempted last year at the federal level. Minnesota is committed to market-based reform and to open, ongoing public debate about our policy changes. While health system reform perished at the federal level, Minnesota's health system reform advanced. Our progress can be explained by a number of factors:

- There has been bipartisan agreement and demonstrated success with health system reform implementation.
- Reforms focus on personal choice and responsibility, not employer or government mandates.
- Minnesota seeks to change market conditions

by creating incentives that put providers, not government, in control of reducing the growth in costs through more efficient delivery of services.

- Health system reform in Minnesota applies multiple approaches, including insurance reforms, tactics to improve access to health care services, incentives for prevention, and a focus on patient outcomes.

Minnesota's success also has depended on its incremental, deliberate approach to reform and its broad-based, open discussion of issues and alternative solutions. It is no accident that we have so many task forces, advisory committees, hearings, and forums. The Legislature uses the feedback, ideas, and critiques to modify and improve MinnesotaCare. For example, last year we delayed the implementation of integrated service networks, created community ISNs, accepted the idea of health care cooperatives, and altered solvency requirements.

"Minnesota has made a strong commitment to market-based reform and to open, ongoing debate about policy changes."

Considerations for the Next Round

Minnesotans receive quality health care services at lower costs than the national average. Proud of their quality of life, Minnesotans believe that everyone should have access to quality, affordable health care services. But, while we can agree philosophically, we are less able to agree on how to get there.

Many elements that have driven health system reform in Minnesota have not changed. Concern remains about health care cost, access, and quality. However, the delivery of health care services *has* changed dramatically in recent years and will continue to do so with or without government involvement.

Rapidly rising health care costs and expenditures have driven employers, the principle purchasers of health care services, to seek reform. Employers, especially large employers, have led the way in demanding a variety of cost-containment strategies, such as the use of capitated health plans, preferred provider organizations, volume discounts, and managed care. Additionally, fast-growing health care costs have had a

tremendous impact on state and local government budgets and will keep the government interested in reform. Finally, taxpayers' intensifying demand for no tax increases also will pressure government to reduce growth in its health care expenditures.

Challenges for Minnesota's Reform Efforts

Despite these pressures, the political urgency to make further reforms has waned with slower growth in health care costs and a reduction in the number of uninsured Minnesotans. There is less public demand for health system reform than there was a few years ago—and demand drops even more when additional reform means an increase in taxes. Every elected official has heard the messages carried in the recent election results; voters are concerned about pocketbook issues and about the cost and role of government.

Maintaining political momentum and commitment over a number of years poses another challenge. Key leaders of health reform have left office. The 1992 MinnesotaCare authors have been reduced from the "Gang of Seven" to just three original authors.

Nonetheless, health system reform will move forward, in part because Gov. Arne Carlson plays a significant role in the development of MinnesotaCare; additionally, former legislators have left us in a stronger position by initiating reform, and current legislators are committed to participating in constructive debate.

Sure to influence the direction and tone of the discussions on health system reform in the upcoming session are changes in the House of Representatives. The addition of new, more conservative members to committees, and possible changes in committee chairs, could have a dramatic impact.

At this juncture, we can anticipate a bipartisan effort to reach agreement on health system reform issues in the 1995 legislative session, but the recent election results and the mood of the electorate will definitely be reflected in the next round of debate. Let the match begin.

MM

Sheila Kiscaden is an independent-republican state senator from Rochester, Minnesota.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

The Perils of Prozac

Deane C. Manolis, M.D.

ABSTRACT

In seven years, Prozac has become a social phenomenon as well as a medical treatment. This paper reviews the background of the Prozac controversy and summarizes the current psychiatric and medical uses of the drug. Prozac and the other selective serotonin re-uptake inhibitors have been determined to be safe and effective treatment for depression. Physicians are sometimes asked to prescribe the drug for inconsequential reasons, but serious depressions are seen frequently in general medical practice. Physicians thus need a high level of awareness and the capability to treat depression, a major public health problem.

Since its introduction in late 1987, Prozac® (fluoxetine hydrochloride, Dista) has been used by more than 10 million Americans, making it this country's most widely prescribed psychopharmacologic agent. Prozac has become a media phenomenon, arousing more public interest than any drug in recent memory, perhaps ever. The controversy surrounding Valium in the 1970s pales in comparison with the perilous course taken by Prozac in the last seven years. Alternately touted as a wonder drug or accused of being a killer drug, Prozac continues to generate intraprofessional, interprofessional, and public controversy.

BACKGROUND

Prozac received extensive media attention in 1990 and 1991, when it was sensationalized on multiple television talk shows and was the subject of cover stories in both *Newsweek* and *Time*. Since then, Prozac has maintained a high profile on the radio, television, and in print media, as well as in the professional literature. It has been the subject of litigation and the subject of *New Yorker* cartoons. The book, "Listening to Prozac" (pro-Prozac), was countered by "Talking Back to Prozac" (anti-Prozac). Articles on Prozac have appeared in such national publications as *The Wall Street Journal* and *The New York Times*, and in such local publications as *The Minnesota Women's Press* and *Minnesota Update*, a publication for University of Minnesota alumni. The list goes on and on...

The Prozac controversy has centered on the drug's phenomenal popularity vs. its reported ability to induce suicidal and violent behavior. Psychiatrists and other physicians prescribe Prozac widely for two main

reasons: 1) it is an effective treatment for severe depression, and 2) it has few side effects. Additionally, it is quite safe in overdose, an important characteristic for a drug used to treat individuals with depression. After early reports of increased suicide rates and violent behavior associated with the use of Prozac, the FDA reassessed the clinical research. Prozac was pronounced safe and effective,¹ with some precautions, but criticism of the drug continued.

One of Prozac's earliest critics was the Citizens Commission on Human Rights (CCHR), an official-sounding organization that led the early sensational television stories on Prozac. Few people knew that CCHR is a part of the Church of Scientology, an organization that has been in constant opposition to psychiatry since the 1960s.² Two other groups, the National Association of Psychiatric Survivors and the Prozac Survivors' Support Group, also have consistently opposed the use of Prozac.³

Subsequent to the early opposition to Prozac, some members of the mental health professions joined the chorus. Leading this group is Peter Breggin, M.D., a long-time opponent of mainstream psychiatry or "biopsychiatry," who wrote a series of books, including "Toxic Psychiatry"⁴ and "Talking Back to Prozac,"⁴ detailing his criticisms. Operating from a pure psychotherapy orientation, Breggin condemns the "psychopharmaceutical complex" and the biopsychiatrists for the widespread use of psychotropic drugs. Breggin⁵ and a separate group of psychologists⁶ have focused much attention on the relatively poor performance of Prozac in clinical trials, perhaps its most valid criticism.

Finally, the psychiatry mainstream has taken a second look at the

use, and perhaps abuse, of Prozac. Since the publication of Peter Kramer's book "Listening to Prozac" and his use of the term "cosmetic psychopharmacology,"² psychiatrists and other physicians have re-examined how they prescribe Prozac. The faddish nature of the Prozac phenomenon has led some people to request Prozac from their physicians to enhance their success in work or social relationships. There is serious concern about overprescribing Prozac, even to the extent that the manufacturer, Eli Lilly, has published ads reminding physicians against "trivializing a serious illness."

This article reviews the current use patterns of Prozac, offers three points for consideration by primary care physicians, and briefly discusses the treatment of depression. Statements about Prozac apply generally to the other selective serotonin reuptake inhibitors (SSRIs) now available—Zoloft (sertraline hydrochloride) and Paxil (paroxetine hydrochloride); side-effect profiles of the three drugs vary somewhat, but indications and clinical applications are virtually identical.

CURRENT USES OF PROZAC

Two recent review articles with extensive references outline the primary and secondary uses of Prozac in detail.^{8,9} Prozac is, above all, a specific treatment for severe depressions, especially those with neurovegetative symptoms. The drug was specifically developed in the search for a "clean" antidepressant—one that acts only on the serotonin system and does not "spill over" to enhance anticholinergic activity. The relative lack of side effects has been largely responsible for Prozac's popularity. The older tricyclic antidepressants and monoamine oxidase inhibitors have extensive side-effect profiles that make patient compliance a concern, and both the TCAs and MAOIs are dangerous in overdose. With few side effects, Prozac can be taken long enough in high enough dosage to be effective. Released in 1987 with indications only for depression, Prozac is now indicated for the treatment of obsessive-compulsive disorder and soon will be indicated for bulimia,

according to a November 10, 1994, Eli Lilly news release. Older drugs have been used for these conditions, but again, Prozac has a better side-effect profile. Contrary to the older antidepressants, Prozac has been found by many psychiatrists to be effective in treating dysthymia, a milder but persistent depressive disorder.¹⁰ "Off-label" uses have included panic disorder and social phobia, psychiatric conditions that can be quite disabling.⁹

Beyond these disorders, the psychiatric uses of Prozac become broader and more controversial. Critics rightly note that the phenomenal expansion of Prozac use has occurred with only a few other drugs in medicine. As psychiatrists find more uses for the drug, Prozac is being prescribed to many individuals for whom psychotropics would not previously have been prescribed. Cynical critics argue that this may well be a part of the marketing strategy for Prozac,¹¹ but more sanguine observers believe this phenomenon is consistent with the broad neurochemical function of serotonin. Kramer makes a reasonable case for prescribing Prozac for social anxiety and "rejection sensitivity," but we begin to skate on thin ice when we use it to enhance energy or as a "mood brightener."²

A brief review of the non-psychiatric literature over the past two years reveals the broadening medical use of Prozac. Double-blind studies have shown Prozac to be effective in treating bulimia nervosa,¹² premenstrual syndrome,^{13,14} premature ejaculation,^{15,16} and as migraine prophylaxis.¹⁷ A number of double-blind studies have shown high-dose Prozac to be useful for obesity,¹⁸ as well as weight loss and better diabetic control in obese type-II diabetics.¹⁹⁻²¹ (Prozac does *not* help diabetic neuropathy, the treatment of which appears to be mediated by norepinephrine rather than serotonin enhancement.²²)

A number of small open studies have assessed conditions for which Prozac appears useful. These include cataplexy,²³ vasovagal syncope,²⁴ and the emotional lability following brain injury.^{25,26} Additionally, many case reports describe trying Prozac to treat

such diverse conditions as narcolepsy,²⁷ interferon-induced depression,²⁸ elective mutism,²⁹ and Raynaud's phenomenon.³⁰ Finally, the oncology literature includes an extensive review of the uses of Prozac in cancer patients.³¹

A number of other psychiatric uses are reported for Prozac. The so-called obsessive-compulsive spectrum disorders, such as trichotillomania (compulsive hair-pulling),³² neurotic excoriation,³³ and compulsive or self-injurious behavior in the mentally retarded population³⁴⁻³⁶ all have been treated successfully with Prozac.

Prozac has even found use in veterinary medicine, with reports in the popular press describing the successful treatment of compulsive behaviors in dogs. This should not be too surprising, given the ubiquitous presence of serotonin in mammals.

THREE POINTS TO CONSIDER

1. Prozac is a safe and effective treatment for major depression and dysthymic depressions. Prozac's safety has been demonstrated through widespread use; closer examination of the early case reports of violent or suicidal behavior revealed long-standing patterns of aberrant behavior in these patients before they started using Prozac.² According to Eli Lilly, the so-called Prozac Defense in criminal cases has been unsuccessful in 54 of 54 trials.

A number of reports criticize the effectiveness claims made in pre-release clinical studies on Prozac, exemplified by a recent meta-analysis.⁶ Under criticism are the studies' small numbers, relatively small improvement over placebo, and the possibility of unblinding due to side effects. These studies were of relatively short duration, as are most drug studies, but Prozac's effectiveness has been repeatedly demonstrated through long-term clinical use by psychiatrists. Prozac is probably not any more effective than the older antidepressant families in research settings, but patient compliance with Prozac is dramatically higher, so more people respond to treatment.²

Despite its relatively clean side-effect profile, Prozac does have several significant adverse effects. The

drug interferes with cytochrome P-450 enzyme systems, resulting in elevated plasma levels of commonly co-administered drugs.³⁷ (Such side effects do not seem to occur with Sertraline.) Sexual side effects are much more common than originally thought; an estimated 30% to 40% of Prozac users experience such problems as decreased libido and orgasmic dysfunction.^{38,39}

Intense restlessness and agitation is a rare but serious side effect that demands immediate discontinuation of Prozac; it is thought that this effect might cause suicidal behavior.² An additional note on the potential for suicidal behavior: Psychiatrists have long known that *any* antidepressant medication carries some suicide risk. This risk is thought to be due to early improvement of depressive symptoms that allows an individual to mobilize behavior to carry out a suicide attempt. Prozac remains among the safest antidepressants in overdose.⁴⁰ Messiha provides an extensive review of Prozac's side effects, adverse effects, and drug interactions.⁴¹

Despite Prozac's effectiveness, patients usually need some psychotherapy in addition to taking the drug. It is not "artificial paradise encapsulated;"⁴² for most patients, interpersonal and intrapsychic issues remain and frequently need psychotherapeutic attention. Psychologists who have patients on Prozac tell me these patients can work more effectively on such problems when on medication. Conversely, patients sometimes drop out of psychotherapy because they feel "well" on Prozac.

Although Prozac is not addicting or habituating, people often remain on the medication for extended periods. This should not be surprising, since many are suffering from chronic conditions. After being on, off, then back on Prozac, one woman patient told me, "If you ever take me off this drug, I'll break your kneecaps!"

2. Prozac should be reserved for serious illness. Because of all the publicity, physicians may be seeing pa-

tients who wish to be placed on Prozac for inconsequential reasons—individuals who want to be "better than well."¹¹ If we succumb to their requests, we only foster Kramer's observation that we are promoting a drug culture of "cosmetic psychopharmacology."

RESOURCES

Physicians may find the following references useful for patient education or their own reading. The Kramer book is comprehensive and might be of interest to the sophisticated patient.

- Fieve RR. Prozac—questions and answers. New York: Avon Books, 1994.
- Greist JH, Jefferson JW. Depression and its treatment. 2nd ed. Washington, D.C.: American Psychiatric Press, 1992; New York: Warner Books, 1994.
- Kramer PD. Listening to Prozac. New York: Penguin, 1993.
- U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy Research. Depression in primary care, Vol. 1: detection and diagnosis; and Vol. 2: treatment of major depression. Silver Spring, Maryland: U.S. Department of Health and Human Services, 1993.

3. Primary care physicians can be caught in the middle. The popularity of Prozac has magnified the dilemma felt by many busy primary care physicians. When confronted with a hurting patient in the office who is unwilling or unable to see a mental health professional at that time, the physician feels the need to do something *now*. The diagnosis may be unclear, and the physician may be apprehensive about prescribing drugs that are potentially habituating or potentially lethal in overdose, so the easy choice is Prozac. According to an Eli Lilly spokesperson, about 60 percent of all Prozac prescriptions come from non-psychiatrists.

Steven Miles, M.D., a geriatrician and medical ethicist at the University of Minnesota and Hennepin County Medical Center, discusses this issue in a recent University of Minne-

sota alumni publication.¹¹ Miles believes there is the potential for primary care physicians to overprescribe Prozac, but that this possibility merely demonstrates a larger socioeconomic problem—this country's inability to provide or pay for needed mental health services. Thus, the popularity of Prozac may just be a symptom of inadequate access to mental health resources.

THOUGHTS ABOUT TREATING DEPRESSION

As a psychiatrist writing for a general medical audience, I cannot help but use the opportunity to discuss the treatment of depression. Despite ongoing public education, a large percentage of individuals with depressive disorders go untreated, and depression is one of the more common reasons for an individual to see a physician. We have long known that suicide victims usually have seen a physician in proximity to their death. Some thoughts then about treating depression in the primary care setting:

- Above all, physician awareness and recognition are necessary antecedents to treating depression.
- Underrecognized and undertreated, depression costs tens of billions of dollars annually in related medical care, lost productivity, family disruption, and mortality.^{43,44}
- Depression is a common condition; the lifetime risk for a major depressive disorder is 7% to 12% for men and 20% to 25% for women.⁴⁵
- Depression is more common than hypertension in primary care medicine.⁸
- Major depression is a potentially fatal illness with a lifetime mortality (suicide) rate of 15%.⁸
- Ongoing research in affective disorders is rapidly defining chronic or severe depressions as *medical* rather than psychological disorders. These conditions then need to be managed in much the same way as other chronic illnesses. As a rule of thumb, psychiatrists recommend *maintenance* antidepressant medications after the third

depressive episode when the first onset is between age 30 and 40; after the second episode if the onset is between age 40 and 50; and after the first episode if the onset occurs after age 50.

- All physicians see patients who appear to have a primary depressive disorder, but medical conditions can often mimic or precipitate depression. "Medical Mimics of Depression," a series of review articles, addresses this comprehensively.⁴⁶

- Tricyclic antidepressants are no longer the first-line agent for treating most depressions. They are still useful in selected situations, but they have too many potential side effects, particularly in the geriatric population. Prozac and the other SSRIs are now considered first-line medical treatment for severe and/or chronic depressive disorders.

- Finally, most depressions need more than an antidepressant medication for effective treatment. The medical community must support nondiscriminatory funding for all mental health services, so needed resources are available for treating psychiatric disorders.

CONCLUSION

The "Perils of Pauline" ended when the movie was over, but the perils of Prozac continue. The Prozac controversy is far reaching and indicative of larger societal issues that extend beyond the act of prescribing Prozac and beyond the scope of this discussion. Fears of social control, the stigma of mental disorders, turf battles over who treats mental disorders and how, and, above all, debate about how to pay for treatment—these are just some of the issues that have produced the most intense ever public discussion of a psychiatric treatment. In this culture of instant communication, public discussion is to be expected; unfortunately, people needing treatment are often left confused. As informed physicians, we can provide a balanced perspective on Prozac and similar agents for our patients.

We have not reached closure on the Prozac controversy; there will be more to come as neurochemical research refines our understanding and

treatment of the brain/mind/behavior continuum.

MM

Deane Manolis is a psychiatrist in private practice, clinical associate professor of psychiatry at the University of Minnesota, and a past president of the Minnesota Psychiatric Society.

REFERENCES

1. Fluoxetine, suicide and aggression [Review]. *Drug Ther Bull* 1992;30:5-6.
2. Kramer PD. Listening to Prozac. New York: Penguin, 1993.
3. Breggin PR. Toxic psychiatry. New York: St. Martin's Press, 1991.
4. Breggin PR. Talking back to Prozac. New York: St. Martin's Press, 1994.
5. Breggin PR. Talking back to Prozac. The Rights Tenet (St. Paul, Minnesota) 1994; Summer: 3-4.
6. Greenberg RP, Bornstein RF, Zborowski MJ, Fisher S, Greenberg MD. A meta-analysis of fluoxetine outcome in the treatment of depression. *J Nerv Ment Dis* 1994;182:547-51.
7. Eli Lilly. Trivializing a serious illness [Advertisement]. *Psychiatr News* 1994; 29(9):19.
8. Stokes PE. Fluoxetine: a five-year review [Review]. *Clin Ther* 1993;15:216-43.
9. Messiha FS. Fluoxetine: a spectrum of clinical applications and postulates of underlying mechanisms [Review]. *Neurosci Biobehav Rev* 1993;17(4):385-96.
10. Hellerstein DJ, Yanowitch P, Rosenthal J, et al. A randomized double-blind study of fluoxetine versus placebo in the treatment of dysthymia. *Am J Psychiatry* 1993; 150:1169-75.
11. Broderick R. Prozac pro and con. *University of Minnesota Update* 1994; 21(5):1-3.
12. Bretz WA, Krahn DD, Drury M, Schork N, Loesche WJ. Effects of fluoxetine on the oral environment of bulimics. *Oral Microbiol Immunol* 1993;8:62-4.
13. Wood SH, Mortola JF, Chan YS, Moossazadeh F, Yen SS. Treatment of premenstrual syndrome with fluoxetine: a double-blind, placebo-controlled, crossover study. *Obstet Gynecol* 1992;80:339-44.
14. Elks ML. Open trial of fluoxetine therapy for premenstrual syndrome. *South Med J* 1993;86:503-7.
15. Waldinger MD, Hengeveld MW, Zwinderman AH. Paroxetine treatment of premature ejaculation: a double-blind, randomized, placebo-controlled study. *Am J Psychiatry* 1994;151:1377-9.
16. Forster P, King J. Fluoxetine for premature ejaculation [Letter]. *Am J Psychiatry* 1994;151:1523.
17. Adly C, Straumanis J, Chesson A. Fluoxetine prophylaxis of migraine. *Headache* 1992;32:101-4.
18. Wise SD. Clinical studies with fluoxetine in obesity [Review]. *Am J Clin Nutr* 1992;55(suppl):1815-45.
19. O'Kane M, Wiles PG, Wales JK. Fluoxetine in the treatment of obese type 2 diabetic patients. *Diabetic Med* 1994; 11:105-10.
20. Gray DS, Fujioka K, Devine W, Bray GA. A randomized double-blind clinical trial of fluoxetine in obese diabetics. *Int J Obes* 1992;16(suppl):567-72.
21. Kutnowski M, Daubresse JC, Friedman H, et al. Fluoxetine therapy in obese diabetic and glucose intolerant patients. *Int J Obes* 1992;16(suppl):563-6.
22. Max MB, Lynch SA, Muir J, Shoaf SE, Smoller B, Dubner R. Effects of desipramine, amitriptyline, and fluoxetine on pain in diabetic neuropathy. *N Engl J Med* 1992; 326:1250-6.
23. Frey J, Darbonne C. Fluoxetine suppressed human cataplexy: a pilot study. *Neurology* 1994;44:707-9.
24. Grubb BT, Wolfe DA, Samoil D, Temesy-Armos P, Hahn H, Elliott L. Usefulness of fluoxetine hydrochloride for prevention of resistant upright tilt induced syncope. *PACE* 1993;16:458-64.
25. Sloan RL, Brown KW, Pentland B. Fluoxetine as a treatment for emotional lability after brain injury. *Brain Inj* 1992; 6:315-9.
26. Seliger GM, Hornstein A, Flax J, Herbert J, Schroeder K. Fluoxetine improves emotional incontinence. *Brain Inj* 1992; 6:267-70.
27. Wing YK, Lee S, Chiu HS, Ho CK, Chen CN. A patient with co-existing narcolepsy and morbid jealousy showing favorable response to fluoxetine. *Postgrad Med J* 1994;70:34-6.
28. Levenson JL, Fallon HJ. Fluoxetine treatment of depression caused by interferon-alpha. *Am J Gastroenterol* 1993;88: 760-1.
29. Black B, Uhde TW. Fluoxetine treatment of elective mutism. *J Am Acad Child Adolesc Psychiatry* 1994;33:1000-6.
30. Bolte MA, Avery D. Case of fluoxetine-induced remission of Raynaud's phenomenon—a case report. *Angiology* 1993;44: 161-3.
31. Schuster JL, Stern TA, Greenberg DB. Pros and cons of fluoxetine for the depressed cancer patient [Review]. *Oncology* 1992; 6:45-50,55-6.
32. Sheikah SH, Wagner KD, Wagner RF Jr. Fluoxetine treatment of trichotillomania and depression in a prepubertal child. *Cutis* 1993;51:50-2.
33. Gupta MA, Gupta AK. Fluoxetine is an effective treatment for neurotic excoriations:

case report. *Cutis* 1993;51:386-7.

34. Bodfish JW, Madison JT. Diagnosis and fluoxetine treatment of compulsive behavior disorder of adults with mental retardation. *Am J Ment Retard* 1993;98:360-7.

35. Sovner R, Fox CJ, Lowry MJ, Lowry MA. Fluoxetine treatment of depression and associated self-injury in two adults with mental retardation. *Journal of Intellectual Disability Research* 1993; 37:301-11.

36. Warnock JK, Kestenbaum T. Pharmacologic treatment of severe skin-picking behaviors in Prader-Willi syndrome. Two case reports. *Arch Dermatol* 1992;128:1623-5.

37. Physicians Desk Reference 1994. Montvale, New Jersey: Medical Economics Data Production Co., 1994.

38. Jacobsen FM. Fluoxetine-associated sexual dysfunction and an open trial of treatment with yohimbine. *J Clin Psychiatry* 1992;53:119-22.

39. Walker PW, Cole JO, Gardner EA, et al. Improvement in fluoxetine-associated sexual dysfunction in patients switched to bupropion. *J Clin Psychiatry* 1993;54:459-65.

40. Borys DJ, Setzer SC, Ling LJ, Reisdorf JJ, Day LC, Krenzelok EP. Acute fluoxetine overdose: a report of 234 cases. *Am J Emerg Med* 1992;10:115-20.

41. Messiha FS. Fluoxetine: adverse effects and drug-interactions [Review]. *J Toxicol Clin Toxicol* 1993;31:603-30.

42. Artificial paradise encapsulated [Editorial]. *Lancet* 1994;343:865-6.

43. Greenberg PE, Stiglin LE, Finkelstein SN, Berndt ER. The economic burden of depression in 1990. *J Clin Psychiatry* 1993; 54:405-18.

44. Klerman GL, Weissman MM. The course, morbidity, and costs of depression. *Arch Gen Psychiatry* 1992;49:831-4.

45. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy Research. Depression in primary care, Vol. 1: detection and diagnosis. Silver Spring, Maryland: U.S. Department of Health and Human Services, 1993.

46. Pies RW (guest ed). Medical mimics of depression [Multiple reviews]. *Psychiatric Annals* 1994;24:519-51.

Interested in an investment program that uses no-load mutual funds?



ADVISORY
SERVICES

One that also offers:

- Professional management without commissions*
- Asset allocation
- Consolidated reporting

If this sounds like a better way to invest, call today and ask me about our SAM program.

Wayne E. Bernardo

2500 Foshay Tower
Minneapolis, MN 55402

(612) 337-8484

(800) 755-5877

*Investors in SAM pay a small annual fee based on account value, nominal transaction costs occur

LINSCO/PRIVATE LEDGER A REGISTERED INVESTMENT ADVISOR

SPECIALISTS

EMERGENCY MEDICINE & URGENT CARE

Continued growth has resulted in TWO outstanding opportunities at **MARSHFIELD CLINIC** — a major referral center in a pleasant small town setting.

- More than 27,000 ED visits with double/triple coverage during peak times
- 425 physician specialists representing all branches of medicine and surgery providing support core and services
- Adjacent to Saint Joseph's Hospital, a 525-bed acute care teaching facility
- Attractive compensation package and full partnership in 2 years and no buy-in
- Pleasant, safe, central Wisconsin community of 20,000, four-season recreation, excellent schools, superb living environment



Send CV to: **Cindy M. Schuster, Assistant Director,
Medical Staff Development, Marshfield Clinic,
1000 North Oak Avenue, Marshfield, WI 54449-5777**

Or call: 1-800-782-8581, ext. 9-3725 Fax 715-387-5240

EDE/M/E/H/V

Associate Physician

Pilot City Health Center • 1313 Penn Avenue North, Minneapolis
\$5,712-9,540 per Month

Part-time and full-time schedules available for a BC/BE Family Practitioner or Internist.

Pilot City Health Center is a community-based ambulatory primary health clinic and a department of Hennepin County in the City of Minneapolis. Established in 1968, we provide high quality health care to families in the Near North and Camden neighborhoods.

To inquire or apply, please call (612) 347-2277 or send your CV to Hennepin County Medical Center Human Resources, Health Services Division, 701 Park Avenue, Minneapolis, MN 55415.



Hennepin County is an Affirmative Action Employer

Associate Medical Director

HealthPartners, one of the largest health care organizations in Minnesota with more than 600,000 members, is currently seeking an Associate Medical Director to support the Medical Director of our Groups Division in providing superior medical leadership and management for HealthPartners.

Your role is to provide leadership for divisional quality and utilization activities; participate in quality, utilization and consulting activities; provide leadership for medical policy development and implementation; and oversee medical input to the development of data and information systems.

You must be Board Certified with a MN license, have five years of full-time experience in clinical practice, be currently practicing in the primary care field and willing to practice on a limited basis. Also required is management experience in a clinical setting and completion of or be working towards an advanced degree in business, health policy or related field.

We offer a competitive salary and comprehensive benefits package. For consideration or more information, please call Susan Wyatt at (612) 883-5323 or send CV to: HealthPartners, 8100 34th Ave. South, P.O. Box 1309, Minneapolis, MN 55440-1309.



HealthPartners

The HealthPartners family of health plans and health-related companies include Group Health, MedCenters, and Ramsey HealthCare. EO/AA Employer.

Dementia and Alzheimer's Disease

Indications, Diagnosis, and Treatment

Richard Golden, M.D.

ABSTRACT

At least 6 million Americans suffer from some form of dementia. More than half of these patients are afflicted with Alzheimer's disease, a progressive, degenerative neurological disorder. Reaching the diagnosis of Alzheimer's, however, is often difficult since Alzheimer's can be accurately diagnosed only after all other options are ruled out. The process is painstaking, but it's also the crucial link in ensuring proper diagnosis and treatment.

There's no cure yet for Alzheimer's, but researchers are narrowing in on possible causes of the disease and identifying patients who may be predisposed to developing it. Some of the most compelling research focuses on the presence of one or more of the apolipoprotein E4 genes.

Researchers also continue to develop new drugs and physical therapies. In the Twin Cities, several drug studies are underway, and community resources are available to provide Alzheimer's patients and their families with information on everything from support groups to assisted-living arrangements.

The recent disclosure by former President Ronald Reagan that he suffers from Alzheimer's disease has thrust the mind-crippling disorder back into the public spotlight. Reagan is among an estimated 4 million Americans who live with Alzheimer's, a disease almost always characterized by chronic memory loss. But forgetfulness alone is not a diagnosis of dementia, and dementia doesn't necessarily indicate Alzheimer's.

We do know that Alzheimer's is the most common form of dementia, and Alzheimer's sufferers account for more than half of the up to 6 million dementia patients in the United States (see the figure, page 27, for a breakdown of dementia origins). Those numbers are expected to steadily increase as baby boomers grow older. With the potential for increased incidence of Alzheimer's, accurate diagnoses, appropriate drug and physical therapies, and referrals to community programs have become crucial to effectively treating the Alzheimer's patient.

Many of us will become more forgetful as we get older. For physicians, it remains difficult to distinguish Alzheimer's from other forms of dementia because Alzheimer's is diagnosed after all other conditions have been ruled out. The diagnosis is often determined by the examining neurologist or psychiatrist and most likely is based in part on interviews of the patient and the patient's close friends or relatives, since they can tell the physician what the patient often can't. The interviews provide an assessment of the patient's performance over time, a useful tool in detecting the early onset of Alzheimer's.

DEMENTIA

SYMPTOMS

Evaluating symptoms is the first step in distinguishing between Alzheimer's and non-Alzheimer's dementia. Patients with non-Alzheimer's dementia have some symptoms similar to Parkinson's disease. These symptoms include prominent and very graphic visual hallucinations, apathetic behavior, and poor performance on psychometric tests. Patients with non-Alzheimer's dementia also tend to experience the onset of dementia more quickly than patients with Alzheimer's.

Patients with non-Alzheimer's dementia also may exhibit motor disturbances, although not as complex or severe as Parkinson's. Tremors are typically not present, and patients usually show only one or two of the other cardinal symptoms of Parkinson's.

The American Academy of Neurology has set new standards for routine dementia screening. The standard workup consists of blood cell count, serum electrolytes, glucose, BUN/creatinine, liver and thyroid function tests, serum vitamin B12, and syphilis serology. HIV testing, sedimentation rate, chest x-ray, urinalysis, lumbar puncture, and neuropsychological testing also may be helpful.¹

NEUROPSYCHOLOGICAL TESTING/ DEMENTIA RATING SCALE

Neuropsychological testing is a comprehensive means of evaluating a patient's global cognitive and cerebral functions. It may be especially helpful in evaluating patients whose initial examination is borderline or suspicious.¹ The clinical dementia rating scale is also helpful in evaluating a patient's cognitive processes.

The rating scale looks at the patient's memory, orientation, judgment, problem solving, community involvement, home life, hobbies, and interpersonal relationships. Both types of testing are helpful in distinguishing between dementia and non-dementia disorders such as depression.¹

VASCULAR DEMENTIAS

Vascular dementias involve cognitive impairment associated with some type of vascular lesion. Three neurobehavioral syndromes have been linked to vascular disorders: the lacunar state, thalamic dementia, and subcortical arteriosclerotic encephalopathy—also called Binswanger's dementia.

Symptoms of patients exhibiting the lacunar state include sudden hemiparesis, dementia, dysarthria, pseudobulbar palsy, crying, small-stepped gait, and urinary incontinence. These patients also have behavioral features usually attributable to prefrontal lesions, such as lack of volition and akinetic mutism syndromes.

Thalamic dementia is the rarest form of vascular dementia. In patients with thalamic dementia, bilateral infarction in the distribution of the paramedian thalamic artery is present. This form of dementia is often marked by apathy, impaired attention, impaired mental control, and anterograde and retrograde amnesia.

Binswanger's dementia is characterized by slowly progressive mental deterioration. Typical physical features include severe gliosis of the white matter and hydration changes, initial fibrosis, and onion-skinning of the medullary arteries. Neurological signs include asymmetric weakness, pseudobulbar palsy, and gait disturbance. Neurobehavioral features include apathy, lack of drive, mild depression, and mood alterations.

Individuals at risk for developing a vascular dementia syndrome include patients who have a history of smoking, hypertension, heart disease, diabetes, and elevated cholesterol. Examination should pay particular attention to the cardiovascular system and should include assessments for atrial fibrillation, endocarditis,

myocardial infarction, coronary artery disease, and polycythemia.

Several clinical trials are underway to develop treatments for vascular dementias. Pentoxifylline, a phosphodiesterase inhibitor, produced positive effects for patients in several blind placebo studies. Nimodipine, a calcium channel blocker, also demonstrated improvement in some patients.

ALZHEIMER'S DISEASE

SYMPTOMS

Patients with Alzheimer's exhibit changes in personality and social skills. They also may become socially uninhibited or lose all initiative and interest in activities. These patients often have delusions, hallucinations, and sleep disorders. They sometimes show grossly inappropriate judgment and sometimes are misdiagnosed as being depressed or psychotic.

Clearly, the most significant risk factor for Alzheimer's is age. As we get older, our risk of contracting the disease increases. It is estimated that the disease strikes 3.5 percent of those 65 to 74 years old. Among 85-year-olds, however, the rate of Alzheimer's incidence jumps to 13 percent. Besides age, other risk factors aren't quite as clear.²

GENETIC PREDISPOSITION

Molecular genetic studies have suggested that certain genes could indicate a familial link in the transmission of Alzheimer's. Mutations in the gene for the amyloid precursor protein have been observed in some families, although these cases have been rare. Some association has been demonstrated between familial transmission of Alzheimer's and the presence of a locus on chromosome 21. Other familial cases have shown a locus on chromosome 14.

Some of the most compelling evidence for an underlying cause of Alzheimer's came from research conducted by scientists at Duke University Medical Center. They found that 64% of individuals with Alzheimer's have a significantly higher frequency of apolipoprotein E type-four (apo E4) alleles and a lower frequency of apo E3. The Duke team concluded that the onset of Alzheimer's is high-

ly dependent on which of the three types of blood protein are present.³ Further study led Duke researchers to focus on the brain's microtubules. The scientists found that the information-carrying microtubules were more likely to break down faster in people with E4 versions of apo E, compared with people with the E3 gene.^{3,4}

Researchers are quick to clarify that apo E4 alone does not cause Alzheimer's, but it may accelerate onset of the disease when coupled with other variables, such as environmental factors. For example, Richard Mayeux, M.D., of New York's Neurological Institute says head injuries do not appear to increase the risk of Alzheimer's in the absence of apo E4, but they increase the risk tenfold if apo E4 is present. Duke University is currently working with a pharmaceutical company to design a drug that could mimic apo E3 to keep the track stable and preserve the nerve, thereby delaying the onset of Alzheimer's.³

Other researchers suspect that an excessive accumulation of iron in the brain may play a role in the onset of Alzheimer's. A study headed by James Connor, M.D., at Penn State University's College of Medicine suggests there is an overabundance of iron in the cells surrounding the Alzheimer's plaques on the brain.³ Connor says a chromosomal gene may be reacting to the iron, then ordering the body to produce amyloid protein, which causes rope-like tangles in the brain that are characteristic of Alzheimer's patients.⁵

OTHER POSSIBLE CAUSES

The extent to which aluminum plays a role in causing Alzheimer's is controversial. Most experts agree that aluminum accumulates in neurons within the neurofibrillary tangle, but experts disagree on whether this is a cause or effect relationship.

Some evidence suggests that a low education level may be linked to the development of Alzheimer's. The association between education and cognitive impairment is currently being studied to determine whether deficiency in early brain development could explain the high frequency of

mental impairment in elderly nuns with low education levels.

Other research suggests people with high occupational exposures to electromagnetic fields (EMFs) are much more likely to develop Alzheimer's. Eugene Sobel, M.D., University of Southern California, found that the onset of Alzheimer's is unusually high in dressmakers and tailors.⁵ Further study revealed that industrial and home sewing machines produce much larger EMFs than other appliances and that people who regularly use sewing machines have the greatest exposure of people in any occupation—up to three times that of electric power-line and cable workers.⁶

Results of another study suggest a genetic link between Alzheimer's and Down syndrome. The study, published in August 1994, suggests that young women whose babies suffer from Down syndrome are five times more likely than other mothers to develop Alzheimer's.⁷

PREDICTIVE TESTING

In November 1994, researchers at Brigham and Women's Hospital and Harvard Medical School published a study suggesting tropicamide may be helpful in diagnosing Alzheimer's disease, even before the patient exhibits Alzheimer's symptoms. Tropicamide, used to dilate pupils in routine eye exams, reportedly dilated the pupils of Alzheimer's sufferers about four times more readily than it did in people without Alzheimer's. Medical experts call the discovery exciting but say further research is needed before the technique can be proven.

Researchers at the Albert Einstein College of Medicine in New York developed a test that, for the first time, can predict the onset of Alzheimer's in older people four years or more in advance. The tests, which detect subtle memory flaws that often precede Alzheimer's, were given to 317 elderly residents of the Bronx.⁸ Results of the study allowed researchers to successfully predict that, over a four-year period, 95% of the subjects would remain free of dementia.⁸ The tests were less accurate—but still convincing—in predicting who is likely to fall victim to Alzheimer's. Elev-

en of 13 subjects with the poorest test scores eventually developed Alzheimer's, an accuracy rate of 85%.^{8,9} David Masur, M.D., lead author of the study, says the tests can help determine which patients should undergo more thorough evaluation and which patients can be reassured they have little short-term risk of developing Alzheimer's.⁹

New research focuses on clinical biomarkers in assessing a patient's risk for developing Alzheimer's. According to Murray Raskind, M.D., markers that may prove useful in diagnosing Alzheimer's or predicting its future course include phosphorylated tau assays, evaluation of potassium channels in fibroblasts, and measurements of beta-amyloid precursor protein (as presented at the conference "Dementia: Practical Patient Management" by the Association for Research in Nervous and Mental Disease and the New York Academy of Medicine, December 1994).

TREATMENT PROTOCOLS

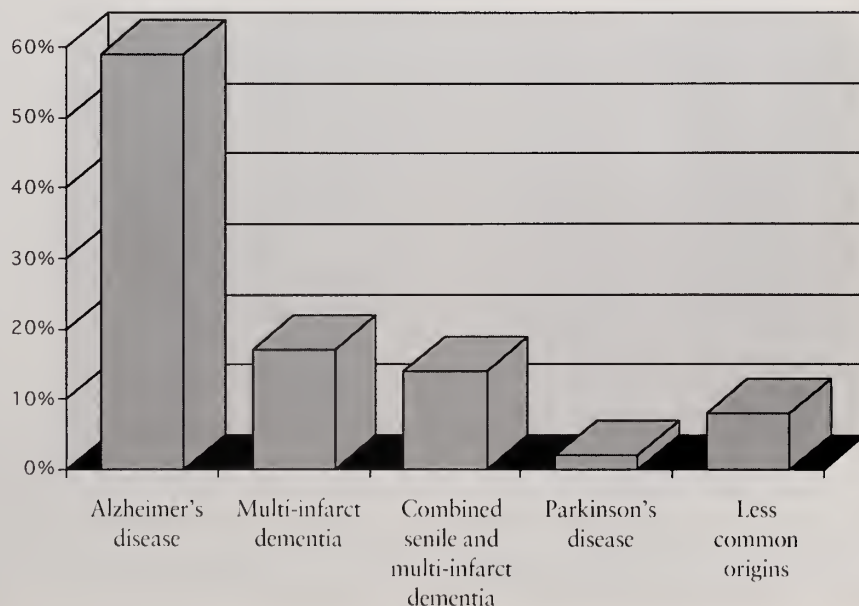
Effectively treating the symptoms of Alzheimer's significantly improves the patient's quality of life. In treating delusions and hallucinations, haloperidol, clozapine, phenothiazines and fluphenazine, buspirone,

trazodone, propranolol, valproic acid, carbamazepine, benzodiazepines, and lithium have all been somewhat helpful in symptom-specific situations. Tricyclic antidepressants, such as nortriptyline, desipramine, and doxepin, have all been used to treat depression. Patients with sleep disorders may also respond to tricyclic antidepressants, as well as trazodone, chloral hydrate, phenothiazines, and benzodiazepines.

Because of inflammatory changes like brain plaques found in Alzheimer's patients, non-steroidal anti-inflammatory drugs are being used to treat some patients, and midodrine is currently being used in clinical trials. According to Leon J. Thal, M.D., midodrine acts to improve vascularity by maintaining adequate blood perfusion. The drug is especially helpful in Alzheimer's patients on multiple medications, since multiple drug therapy often decreases blood pressure (as presented at the conference "Dementia: Pharmacotherapy Past and Future" by the Association for Research in Nervous and Mental Disease and the New York Academy of Medicine, December 1994).

The only drug currently approved by the FDA for primary therapy of Alzheimer's is Cognex (tacrine). The

Dementia Origins



Table

Current local studies in Alzheimer's disease

Organization	Drug	Study director	Contact
St. Poul-Romsey Medical Center	Nimodipine Sabeluzole	Dr. Tom Alo	Joon Horbal, 612/221-2752
Minneapolis Clinic of Neurology	Besipiridine	Dr. James Allen	Dorothy Munson, 612/588-0661
University of Minnesota	CI-979 Prednisone ABT 418 (nicotine-like substance administered via patch)	Dr. David Knopman	Morgoret Prod'Homme, 612/624-1404

drug is expensive, and some patients who've used it have shown liver toxicity. In other individuals, however, it has shown a prominent positive effect. Tacrine works to slow the destruction of acetylcholine, a brain chemical that is deficient in Alzheimer's patients. Medical experts have contrasting views on the efficacy of tacrine for Alzheimer's primary therapy.

ESTROGEN REPLACEMENT

There is some support in the medical field for the role of estrogen in fighting Alzheimer's and other memory disorders in women. In November 1993, Victor Henderson, M.D., a neurology professor at the University of Southern California, announced the results of two long-term studies that showed reduced incidence of Alzheimer's in women taking estrogen.¹⁰ The first study included 253 women. Of those who underwent estrogen therapy, 7% were eventually diagnosed with Alzheimer's, compared with 18% of women who did not take the hormone.⁹ In the second study, which ran from 1981 to 1992, estrogen replacement reduced women's risk of developing Alzheimer's by 30% to 40%.¹⁰

LOCAL CLINICAL TRIALS
AND RESOURCES

In the Twin Cities, several drugs are in clinical trials for primary therapy of Alzheimer's. Studies are being conducted at St. Paul-Ramsey Medical Center, the University of Minnesota,

and the Minneapolis Clinic of Neurology (see the table for specific study locations and contact persons).

In his disclosure letter to the American public, former President Reagan cited the difficulties Alzheimer's poses to family members of those who suffer from the disease. In Reagan's words, "Unfortunately, as the disease progresses, the family often bears a heavy burden. I only wish I could spare Nancy from this painful experience."¹¹

Several Twin Cities organizations have developed programs to provide information on caring for the Alzheimer's patient. The Minneapolis Neuroscience Institute (MNI) is an umbrella organization that brings together specialized services available to patients with neurological conditions, including dementia and Alzheimer's. The MNI offers a variety of education, clinical research, diagnostic, and therapeutic programs to patients and their families.

Another group that acts as a program resource for Alzheimer's patients is the Abbott Northwestern Task Force on Alzheimer's Disease. The task force identifies and evaluates support groups, classes, and training opportunities for caregivers. Working together with the Minneapolis-St. Paul Chapter of the Alzheimer's Association and the Wilder Foundation, the task force can assist Alzheimer's patients and their families in choosing a physician or selecting appropriate community resources.

THE CONTINUING CHALLENGE

Within the past year alone, medical science has made great strides in isolating and identifying genetic and environmental risk factors and possible causes of Alzheimer's. As we're now beginning to see the first wave of drug therapy for Alzheimer's sufferers, it has become increasingly important to rule out other forms of dementia and non-dementia syndromes before treating patients for Alzheimer's.

While there still is no cure for the disease, tacrine has been shown in many patients to retard the progression of Alzheimer's. These patients and their families can be encouraged by medical research to further isolate the causes of the disease and to formulate drug therapies to slow its advancement.

Former President Reagan said he went public with his illness in the hope that it would raise public awareness and promote a clearer understanding of the disease.¹¹ Perhaps it has. As health care providers, we need to do more than raise awareness and improve understanding. We need to continue medical research and unite drug therapies with physical therapy and community resources to minimize the impact of Alzheimer's disease on patients and their families.

MM

ACKNOWLEDGMENTS

The author acknowledges the assistance of Candace Tilquist, executive

director of the Task Force on Alzheimer's Disease, Abbott Northwestern Hospital, Minneapolis, Minnesota, and David Knopman, M.D., researcher and expert on dementia and Alzheimer's disease, University of Minnesota, Minneapolis.

Richard Golden is a staff neurologist at Noran Neurological Clinic in Minneapolis. He is chair of the Minneapolis Neuroscience Institute, chair of the Alzheimer's Disease Task Force, and former head of the neuroscience department at Abbott Northwestern Hospital.

REFERENCES

1. Lanska D. Practice parameter for diagnosis and evaluation of dementia. *Neurology* 1994;44(11):2203-6.
2. Brown D. New eye-dilation test may detect Alzheimer's in its earliest stages. *St. Paul Pioneer Press* 1994 Nov. 11; Sect. A:1.
3. Cotton P. Alzheimer's/apo E link grows stronger. *JAMA* 1994;272:1483.
4. Goedert M, Strittmatter W, Roses A.

Risky apolipoprotein in brain. *Nature* 1994; 372:45.

5. Alzheimer's sleuths suspect too much iron disease's cause. *Chicago Tribune* 1994 Sept. 30; Sect. 1:7.

6. Associated Press. Electromagnetic fields may be tied to Alzheimer's disease, studies indicate. *Chicago Tribune* 1994 Aug. 2; Sect. 1:5.

7. Schupf N, Kapell D, Lee JH, Ottman R, Mayeux R. Increased risk of Alzheimer's disease in mothers of adults with Down's syndrome. *Lancet* 1994;344:353.

8. Masur D, Sliwinski M, Lipton R, Blau AD, Crystal HA. Neuropsychological prediction of dementia and the absence of dementia in healthy elderly persons. *Neurology* 1994;44:1427-32.

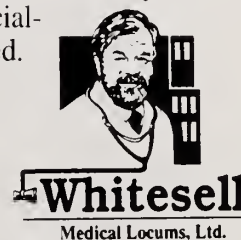
9. Associated Press. Tests may predict risk of Alzheimer's: a chance to alert potential sufferers. *Chicago Tribune* 1994 Aug. 30; Sect. 1:6.

10. Kotulak R. How the brain keeps itself fit: discovery of healing chemicals offers new hope for treating Alzheimer's and other diseases that steal memory and reason. *Chicago Tribune* 1994 Sept. 18; Sect. 1:1.

11. Reagan's letter. *The Washington Post* 1994 Nov. 6; Sect. A:24.

MINNESOTA LICENSED LOCUM TENENS PHYSICIANS AVAILABLE!

For hassle-free help to cover for vacations or absences from your practice, call today. All major specialties covered. Medical review officers now on staff.



Whitesell Medical Locums, Ltd.
Eight First Ave. S.
Buffalo, MN 55313
Phone: 800/876-7171

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 260 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice for the Region
- Orthopaedics - Detroit Lakes, Bemidji
- General Surgery - Wahpeton
- Psychiatry ■ OB/GYN
- Urgent Care ■ ENT
- Rheumatology ■ Pediatrics - Bemidji
- Internal Medicine - Detroit Lakes



For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010

MeritCare Medical Group
737 Broadway • Fargo, ND 58123



CRIMMINS

(continued from page 7)

insuring their employees. It seeks to level the insurance playing field by standardizing benefits, which could then be upgraded at additional cost. With basic coverage defined by law, health plans would then be free to compete in such areas as price, reputation, and convenience of services offered. Crimmins believes state government still has a role to play—in making sure health plans are accountable. The state also has an obligation to subsidize those who are unable to pay for their own insurance premiums and to maintain its traditional public health role in epidemiologic data collection, infectious disease control, environmental health, and public education.

Crimmins says he is uncomfortable with the prospect of doctors being at direct financial risk for the cost of medical services because of the inherent conflict of interest between their role as patient advocate

and their financial commitment to the health plan. And he thinks the jury is still out on integrated service networks ("How are they different from HMOs?"). What he does envision are competing networks of hospitals and physicians and large multispecialty or single-specialty practices. Opposed to fee schedules, Crimmins says fees should be negotiated as they are in all other areas of our economy.

The new legislation also includes tort reform, seeking to abolish what Crimmins calls "windfalls in the tort system." It asks for a sliding scale cap on attorney contingency fees for awards over \$400,000, and it also calls for caps of \$250,000 on pain and suffering. "We do want to retain the opportunity for patients to seek fair compensation for injuries suffered as a result of negligence," Crimmins emphasizes.

Optimistic about the prognosis of the MMA legislation, Crimmins nevertheless says no one should be deceived into believing that MinnesotaCare will be repealed or that the system can go back to the "good old days." Crimmins suggests it is primarily the marketplace and business groups—not the government—that are driving managed care. "That will not change by repealing MinnesotaCare regulations," he says.

"Physicians have been getting mixed messages for a long time," says Crimmins. "We're told to operate like a business, but then we're expected to behave like a social service and provide charity care. We're told to reduce costs, but when people get sick they expect us to do everything. They want us to use the least expensive providers—but when it's you or your family, you want the best physician money can buy. People want more efficiency and lower overhead, but they expect emergency departments and operating rooms to be ready 24 hours a day."

Combine the lack of cost-containment data and research in cost-effectiveness with the fact that patients today are more aggressive and involved with their care and, therefore, more demanding of services, says Crimmins, and you have a frustrating situation for physicians.

"The current emphasis on prevention and early detection of disease has made us a 'worried well society,'" says Crimmins. "People don't want to know that there's an 80 percent chance nothing is wrong with them. They want to know 100 percent, or as close as possible to that. And the traditional role of doctors has been to reassure, to take the safest route, which has often meant more testing."

Crimmins firmly believes physicians are willing to cooperate to lower costs, but they want to be assured that decisions to limit medical care are based on good clinical research (deciding, for example, that it is not cost-effective to do CPR on patients with certain terminal conditions) and are made in public forums, rather than in corporate boardrooms.

"Rationing decisions are being made now," says Crimmins. "Administrators of various entities decide whether or not to hire an extra doctor, build a clinic, or extend hours—what I call boardroom rationing—often without physician input. Arbitrary utilization review, poorly developed practice parameters, and micro-management of physician practices are the cost-containment methods in use now." This type of limit-setting is contrary to the kind of rational health care decision making Crimmins believes is possible with the passage of the MMA legislation.

While the medical association's current focus is on ensuring that the Quality and Coverage Act passes, the larger goal is to encourage physicians to take a leadership role in the reformed health care system, says Crimmins. "There is enormous potential for physicians and for the future of health care in this state if we can speak in a uniform voice." **MM**

Fran Miller Toubin is a frequent contributor to Minnesota Medicine and a free-lance writer living in Minneapolis.



Aspen Medical Group is an independent, progressive, multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by more than 145 professionals who offer care at nine clinic locations in the Twin Cities. Aspen offers a guaranteed base salary, attractive benefits package and no practice buy in to become a member of the group. For information about practice opportunities, please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. East #200
St. Paul, MN 55108
612/642-2779
Fax 612/642-9441
Equal Opportunity Employer

An Opportunity That Speaks for Itself

MINNEAPOLIS OTOLARYNGOLOGY HEAD AND NECK SURGERY, P.A.

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
(612) 885-6224 or 1-800-842-6469



"We are three Board Certified Otolaryngologists located in an affluent suburb of Minneapolis seeking another physician to join our practice."

"Working in five suburban locations provides a flexible schedule, a varied patient population, an opportunity to build a lucrative practice and the time to do the other things that are important to you."

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

CONTINUING MEDICAL EDUCATION

ST. PAUL - RAMSEY MEDICAL CENTER

Winter/Spring Schedule of Courses

Mark your calendar now for these upcoming conferences:

1995

- February 10 Burn Care Today, St. Paul
- March 2-3 Infection Control in Long-Term Care Facilities, Part I, St. Paul
(May 24-25, Part II)
- March 9-10 Family Medicine Today, St. Paul
- March 17 Occupational Medicine Update, St. Paul
- March 24 HIV Primary Care Conference, Bloomington
- March 30-31 Critical Care 1995: Practical Approaches & Case Discussions, St. Paul
- April 6-7 Obstetrics & Gynecology Update, St. Paul
- April 7 ENT Update, St. Paul
- May 24-25 Infection Control in Long-Term Care Facilities, Part II, St. Paul
(March 2-3, Part I)

Information and registration:

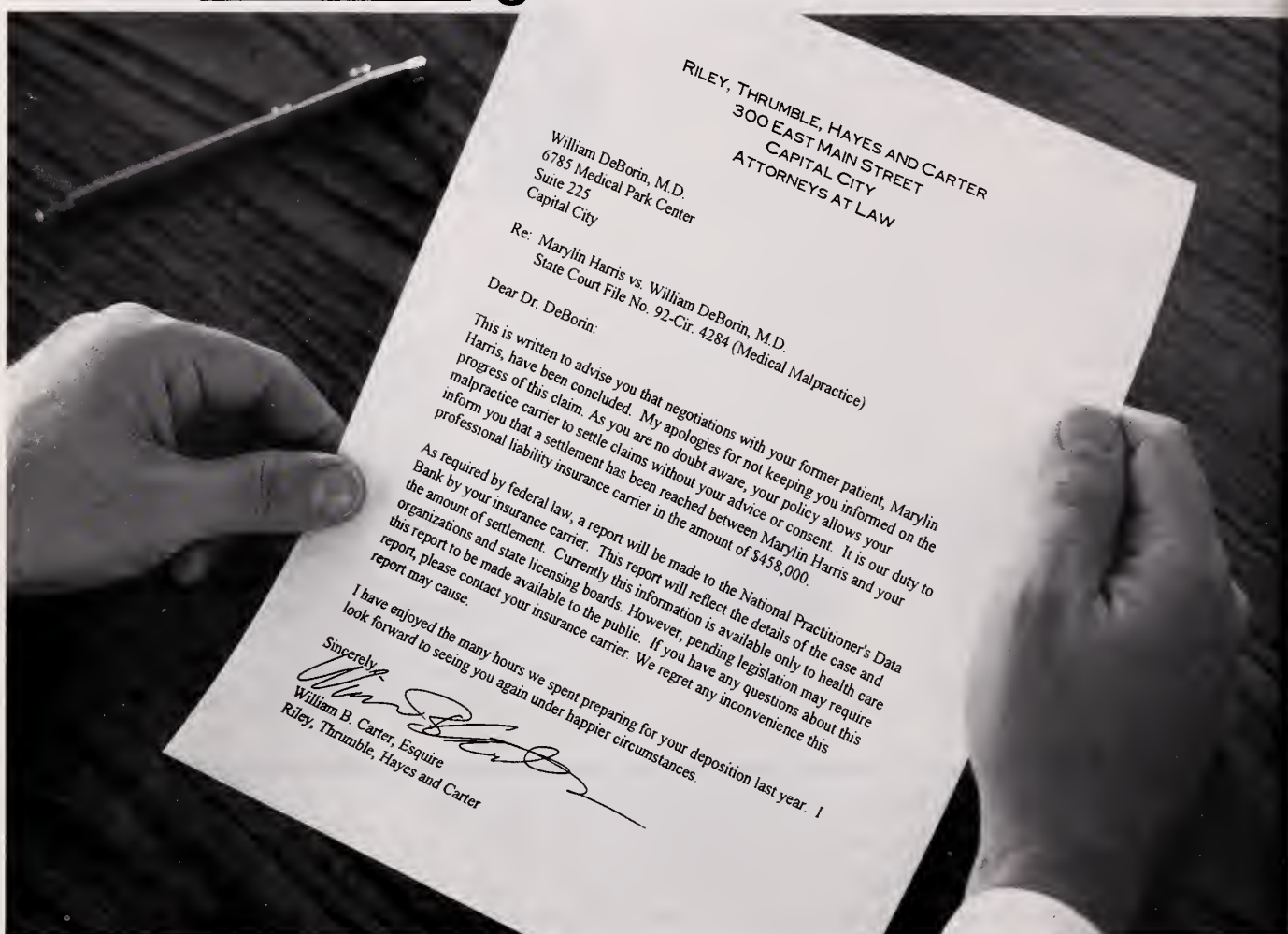
Continuing Medical Education, St. Paul - Ramsey Medical Center,
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992, Fax 612/292-4773

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

Medical Protective Policyowners **NEVER** get letters like this!



Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

INDE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's

800/344-1899



ANNOUNCEMENTS

• • • • •

MMA Will Convene Special Session of MMA House of Delegates

The Minnesota Medical Association House of Delegates will convene on January 7, 1995, at the Northland Inn in Brooklyn Park to consider the MMA bill, the Minnesota Health Care Quality and Coverage Act.

• • •

MMA May Seek Antitrust Relief

In addition to making decisions about the draft of the MMA Quality and Coverage Act, the MMA House of Delegates will consider a separate proposal that the MMA seek state antitrust relief designed to allow physicians, practicing in groups of 20 or fewer, to bargain collectively when they are negotiating reimbursement arrangements with powerful third-party payers. If approved by the House, this proposal would be introduced as separate legislation rather than being included in the Quality and Coverage Act.

• • •

PROVIDER NETWORK SEMINAR IS JANUARY 11

The Minnesota Medical Association, the Minnesota Hospital Association, and the Minnesota Medical Group Management Association will present a seminar on cooperatives, clinics without walls, and other provider-directed networks January 11, 9 a.m. to 4 p.m., at the Northland Inn in Brooklyn Park. The registration fee is \$75 for members and \$125 for non-members. For more information, call Vicki Westling, 612/378-1875 or 800/999-1875.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Board Makes Key Decisions on MMA Bill

The Minnesota Medical Association Board of Trustees made the most difficult decisions—those involving funding—on the draft of a bill entitled “Minnesota Health Care Quality and Coverage Act” at a meeting December 17. Reaffirming MMA support for universal coverage, the MMA board called for a free-rider or “fair share” penalty on state taxes as a way to enforce the mandate that everyone must have health care coverage by 1997. The board reaffirmed that the MMA will seek repeal of the 2 percent tax on medical services and named a number of funding sources to help subsidize health insurance for those who cannot afford to pay. The MMA House of Delegates will reconvene for a special session January 7 to vote on the draft bill.

Funding Sources

The MMA board listed funding sources for MinnesotaCare in the following order of preference: 1) increase the cigarette tax by 40 cents each year for five years, 2) increase the alcohol excise tax, 3) dedicate part of the money raised by the state sales tax to the Health Care Access Fund, 4) place a sales tax on clothing. All of these funding sources may not be needed if the higher priority choices raise enough money to fund the MinnesotaCare program.

The Quality and Coverage bill will also seek to eliminate the transfer of money from the Health Care Access Fund to the General Fund. The governor's budget calls for a transfer of approximately \$30 mil-

lion per biennium from the access to the general fund. Originally, the transfer was designed to help pay for a dramatic increase in the number of people on Medical Assistance and General Assistance Medical Care that the MinnesotaCare program was expected to generate. But the increase never occurred. During the 1994 legislative session, the MMA successfully sought legislation that would shift some of the money back to the Health Care Access Fund, but the governor line-item vetoed that provision.

Data Collection and Analysis

The board approved a number of specific ways to focus the state's data collection and analysis efforts on continuous quality improvement and to streamline the current system. (See pages 36-37 for more information on data collection and analysis.) The draft Quality and Coverage Act will include the following provisions:

- The Minnesota Health Data Institute should remain a public-private partnership between the Data Institute and the Minnesota Department of Health (MDH).

- If there is disagreement between the commissioner of health and the Data Institute, the Legislative Oversight Commission (LOC) should make the final decision. The LOC is a 10-member bipartisan commission, which includes five state senators and five representatives.

- The Data Institute should focus on promoting continuous quality improvement within the health

Q&C continued on page 35



Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

Will Minnesota Keep Its Edge in Health Care Quality?

Minnesota, the healthiest state in the nation, is known for the high quality of its medical care. Will this be true 10 years from now? The answer may depend on us.

There is a real danger that the growing pressure to hold down costs could erode quality unless safeguards are built into the newly evolving health system.

To avert that danger, the MMA is proposing the Minnesota Health Care Quality and Coverage Act, which will make some mid-course corrections in Minnesota's health system reform plans. Quality of care must not only be preserved, but must continue to improve.

As the powerful health plans compete to contain costs, it will become increasingly important for the state to hold the plans accountable for the quality of care they provide. There must be safeguards so the chronically ill and other high-risk patients are not left out in the cold while health plans insure the healthy.

There must be better information for the public. Health plans should be required to let potential enrollees know about any restrictions on coverage before they sign up. Will they need a referral to see a specialist? What type of provider serves as the gatekeeper? Can they see an out-of-network provider? How much extra will it cost? People have

a legitimate need to know what they're buying.

The MMA draft bill includes the following provisions to make health plans accountable for quality of care:

- Require all health plans to offer a standard universal benefits set. This provision will prevent health plans from offering benefits packages designed to attract healthy enrollees and to avoid those with higher risks. Plans would also be allowed to offer supplemental benefits and to offer a variety of cost-sharing options, such as copays and deductibles.

- Forbid health plans to design networks that omit or significantly limit the number of providers who specialize in care for patients with expensive, chronic conditions or whose practice focuses on ethnic minorities.

- Require health plans to offer a point-of-service option that would allow people to seek medical care from any health care providers regardless of whether they are in the network and regardless of specialty.

- Ban health plan/provider contracts that require the provider to withhold or deny care or to refuse to make an appropriate referral in exchange for financial rewards. This would not prohibit capitation or other compensation methods that hold providers financially accountable for caring for an entire patient population.

- Require health plans to pay for

bona fide emergency care for enrollees even if they receive care outside the health plan's network. The plan could require the patient to be transferred to a hospital within the network as soon as possible.

- Revise Minnesota's utilization review laws to make sure utilization review is not used to prevent patients from receiving medically necessary services. For instance, utilization review organizations should be required to give enrollees and providers the written criteria they use to approve or deny care. Currently, only the treating provider is entitled to receive the written criteria and then only after a request for certification has been denied.

- Require health plans to provide clear information about referral policies, including the types of providers who serve as gatekeepers.

Quality improvement rather than cost containment should be the focus of the state's data collection efforts. Data, practice parameters, and technology assessments can help physicians and other providers improve their practices and identify procedures that are inefficient or don't work. Data should not be used to control utilization or to label physicians as "poor quality" solely because they order expensive tests or procedures. No physician should be penalized for treating a sicker mix of patients.

The MMA bill proposes that the Minnesota Health Data Institute facilitate the educational use of data as well as provide information on cost. The institute would also promote continuous quality improvement by the health plans and the development of standards of the "best" medical practice, not necessarily the cheapest. The state agencies that are working on data-related projects should be brought under the auspices of the Data Institute to provide a clearer focus and better communication.

Cost containment is important and should be encouraged, but not at the expense of quality. The MMA's Quality and Coverage Act would make sure that effective safeguards are in place.

• • • • •

.....

LEGISLATIVE PREVIEW

MEDICARE BALANCE BILLING

When the 1995 Minnesota Legislature convenes January 3, the MMA will seek introduction of a bill that would repeal the state law that sets more stringent limits on balance billing to Medicare patients than the national limits. The bill would allow Minnesota non-participating Medicare providers to balance bill up to the federal limit of 115 percent of the non-participating allowed amount.

GEOGRAPHIC EQUITY

The MMA will seek legislation calling for geographic equity in General Assistance Medical Care and Medicaid capitation rates to ensure continued access to care for all Minnesotans.

MEDICARE INEQUITIES

The MMA will seek an appropriation from the 1995 Legislature to enable the attorney general to initiate legal action against the federal government to correct the geographic inequity in Medicare reimbursement rates under both fee-for-service and capitated arrangements.

AG PROPOSES TO EXPAND POWERS OF LICENSING BOARDS

The Attorney General's Office is drafting a bill that would give broad powers to the licensing boards. Under the proposed bill, boards would be able to share private or confidential data with law enforcement agencies if it would "aid in the law enforcement process or promote public health and safety." This is much broader than the current law that requires boards to share data if failure to do so poses a "clear and present danger." In addition, the AG's bill would allow boards to subpoena licensed individuals, require them to testify under oath, and compel them to provide evidence. The MMA is discussing concerns with this bill with the AG's office.

DRAFT OF AG's VULNERABLE ADULT BILL CAUSES CONCERN

The Attorney General's Office is drafting a bill that would put doctors behind bars for failing to report abuse of vulnerable adults. The bill would make it a crime punishable by five years in prison

and/or a \$10,000 fine to fail to report suspected abuse of a vulnerable adult when great bodily harm or death is attributed to maltreatment. When maltreatment is determined to be "serious or recurring," any failure to report is punishable by up to one year in jail, a \$3,000 fine, or both. "Vulnerable adult" is broadly defined in the draft legislation as an adult "regardless of residence or whether any type of service is received, who possesses a physical or mental infirmity or other physical, mental or emotional dysfunction that impairs the individual's ability to, without assistance, provide adequately for their own care and protection from maltreatment." Abusive conduct would include not only hitting and slapping, but also the use of "repeated or malicious oral, written or gestured language." The broad language of this proposal would put physicians at great risk of prosecution and would set back the MMA's campaign to encourage women to talk to their physicians about family violence in the confidential setting of the physician's office. The MMA is meeting with representatives of the AG's office to discuss concerns about this proposed legislation.

Q&C *continued from page 33*

plans, developing report cards and consumer satisfaction surveys, and developing standard definitions and criteria for data collection.

- The MDH should focus on population-based studies and data associated with surveillance, disease prevention and tracking, and tracking expenditure growth limits.

- The Practice Parameter Advisory Committee should be eliminated.

- The Data Analysis Program should be placed under the auspices of the Data Institute.

- The Information Clearinghouse

should be eliminated.

- The Data Institute should disseminate information resulting from data collection efforts, such as the consumer satisfaction survey results and the health plan report cards. The Data Institute should receive funding for this purpose.

- The chair of the Health Technology Advisory Committee (HTAC) should become a member of the Data Institute board, and the number of MMA representatives on the Data Institute should be increased.

- The Data Institute should be given the authority to contract with a vendor to carry out data collection

initiatives.

Public Health and Safety

The board also voted to include a new section in the bill on public safety. The MMA bill calls for the following measures:

- Make failure to use a seat belt a primary offense punishable by a \$100 fine.

- Make failure to wear a helmet while riding a motorcycle, snowmobile, or all-terrain vehicle a misdemeanor punishable by a \$25 fine.

- Require all minors to wear a helmet when riding a bicycle.

State's Data Collection and Analysis Plans Go Forward

Practice Parameter Advisory Committee

Purpose: The 1992 MinnesotaCare legislation established a program in the Minnesota Department of Health to develop, adopt, review, and disseminate practice parameters. The Practice Parameter Advisory Committee (PPAC) advises the commissioner of health, who is responsible for developing and approving practice parameters.

Membership: The 15-member committee must include eight health care professionals, as well as representatives of the research community and medical technology industry. The MMA appoints six members.

Legal Protection: State law authorizes the commissioner of health to approve practice parameters in order to provide malpractice protection for physicians who adhere to them. Adherence to an approved practice parameter was intended to be an absolute defense against an allegation that a provider did not comply with accepted standards of practice in the community. There is doubt, however, that they will provide adequate protection, according to Ted Thompson, MMA legislative counsel.

Current Activities: The PPAC has recommended that the commissioner approve practice parameters for unstable angina based upon those developed by the federal Agency for Health Care Policy and Research. The commissioner has not yet responded to the request. At a recent meeting, some members of the PPAC questioned whether the committee serves a useful function. The MMA bill proposes that the PPAC be eliminated.

Health Technology Advisory Committee

Purpose: The Health Technology Advisory Committee (HTAC) was created to conduct evaluations of health care technologies that could be used

by health plans, employers, and the government in making clinical decisions and in developing policies about the appropriate use of technology. Evaluations consider safety, improvement in health outcomes, clinical effectiveness, and cost-effectiveness. HTAC is an advisory subcommittee of the Minnesota Health Care Commission and the MDH and has no regulatory powers.

Membership: The committee must include a physician, a hospital representative, a health care technology industry representative, and a labor union member.

Current Activities: HTAC published its first evaluation in the spring of 1994 on the costs and benefits of tissue plasminogen activator (t-PA) to treat acute myocardial infarction. (A summary of the report was published in the July *Monitor*.) The committee has selected the following technologies for its next evaluations: prostate specific antigen (PSA) for prostate cancer screening, stereotactic radio-neuro surgery for brain tumors, magnetic resonance imaging for diagnosis of headache, electronic fetal monitoring during labor, high-dose chemotherapy with autologous stem cell rescue for breast cancer, and pancreas transplantation for patients with diabetes. An article on HTAC was published in the November issue of *Minnesota Medicine*.

Information Clearinghouse

Purpose: The Information Clearinghouse within the Minnesota Department of Health was created primarily to help consumers, employers, providers, health carriers, and others obtain information on health care costs and quality in Minnesota. The clearinghouse is responsible for disseminating the information in the health plan action plans, which include provider credentialing requirements, the number and type of providers, plans to improve quality by

the internal use of report cards, outcomes studies and complaint information, and policies to serve high-risk and special needs populations and rural communities. The MMA draft bill proposes that the clearinghouse be eliminated and its functions be performed by the Minnesota Health Data Institute.

Current Activities: The clearinghouse published a "Summary of 1993 HMO Operations in Minnesota," a report including financial, enrollment, and utilization information about HMOs. The clearinghouse also provides a toll-free number that people can call to ask questions about health system reform in Minnesota (800/657-3793 or 612/282-6314). The clearinghouse newsletter, "Health Reform Update," which provides information on Minnesota's health reform activities, is published every other month. In addition, the clearinghouse develops and distributes "user-friendly" summaries of HTAC's evaluations and is responsible for distributing practice parameters developed by PPAC.

Minnesota Health Data Institute

Purpose: The Minnesota Health Data Institute is charged with making recommendations to the commissioner about data collection initiatives, including the expected benefits and the best method of collecting the data and the projected costs. The state's goal is to create an integrated data system that will provide clear information on the cost, quality, and structure of health care services.

Membership: The data institute is a public-private partnership between the commissioner of health and a 20-member board of directors that includes representatives of the state, the insurance industry, health care purchasers, and providers. Two MMA appointees and two alternates serve on the Data Institute board: A. Stuart Hanson, M.D., Richard Dinter, M.D., Donald Asp, M.D., and Michael Murray, M.D.

Current Activities: The patient satisfaction survey and the health plan report card are being developed

Data continued on page 37

MMA Board Adopts Revised Data Policy

The Minnesota Medical Association Board of Trustees in November adopted a revised policy on data collection, analysis, dissemination, and disclosure.

Principles

The new policy adds a key principle stating that physician-specific data should only be released if all criteria for appropriate data disclosure are followed, and it reiterates the following MMA key principles:

- all data must be accurately and scientifically collected, analyzed, and disseminated;
- data should be used primarily for educational, not punitive, purposes;
- patient-specific data must be classified to maintain confidentiality;
- physicians should be notified well in advance about standards, guidelines, or criteria to which they will be held accountable; and

- data systems must be regularly evaluated, updated, and, if necessary, modified.

Legitimate Reasons

The revised policy identifies continuous quality improvement as the primary reason for collecting data and expands the list of legitimate reasons for a data initiative to include the following:

- assess and improve health outcomes;
- identify opportunities to reduce costs that arise from unnecessary, inefficient, and ineffective treatments, procedures, and processes; and
- provide information to help purchasers, patients, and providers make informed decisions.

The report also includes reasons for data collection, which were identified as legitimate in earlier MMA policy statements:

- improve methods of prevent-

ing, diagnosing, treating, and clinically managing illness or disease; and

- reduce clinically significant variations in treatment and improve preventive diagnostic and treatment techniques and methods.

Risk Adjustment

The revised policy also stresses the importance of a risk-adjustment methodology to identify differences in case mix. A clinical severity risk adjustment system should take into account such elements as the patient's age, comorbidities, and risk factors. Data should not be released until appropriate clinical risk adjustment has occurred. MMA policy states that no data should be released that rank providers, and there must be safeguards to prevent the identification of individual providers.

Privacy Classification

A new section of the MMA data policy statement is devoted to the privacy classification of data under Minnesota statute. According to this section, MinnesotaCare law fails to provide privacy protection for patient or provider data collected by the Minnesota Health Data Institute except for the information collected for the consumer satisfaction survey. Therefore, all other data collected by the Data Institute are public and available to anyone. The Data Institute is reviewing this issue and plans to address it in legislation during the 1995 session. Data collected by the commissioner of health and the Data Analysis Unit are protected as private or nonpublic, which means it is accessible to data subjects and to government officials whose duties reasonably require access, but the commissioner has broad discretion to release such data. The law protects the privacy of data identifying patients by requiring the use of unique patient identification numbers. But provider identification numbers are not always required, and there are no explicit safeguards in current law to ensure that provider-specific data, which are disclosed to the public, are valid, consistent, accurate, and meaningful.

• • • • •

Data continued from page 36

under the auspices of the Data Institute. To deal with these responsibilities, the Data Institute has spawned a number of subcommittees. The consumer information task force is working on the types of questions to be included in the consumer satisfaction survey. The technical advisory committee is developing a system to collect, encrypt, transmit, and store claims data on inpatient ('94 and '95) and outpatient ('95 and '96) visits. A task force has been established to deal with permanent rules on collecting data. The committee on ethics and confidentiality is making recommendations on a set of guiding principles to govern access to health care data. The hospital/provider task force is developing recommendations to set common standards and definitions, which would reduce overhead.

Data Analysis Unit

Purpose: The Data Analysis Unit of the Minnesota Department of Health is responsible for working with the Data Institute to develop a plan for an integrated data system. The MDH now calls the unit the Data Analysis Program. DAP plans to develop report cards on health plans and on the all-payer option so consumers can compare them; to develop and execute a process for reviewing and approving practice parameters; and to disseminate reports and practice parameters through the Information Clearinghouse.

Current Activities: DAP is collecting ambulatory, inpatient, and pharmacy claims and enrollment data from selected payers. The purpose of the project is to use the data to address access and quality issues. The MMA draft bill recommends that DAP be placed under the auspices of the Data Institute rather than MDH.

• • • • •

ANNOUNCEMENTS

• • • • •

**SEMINARS ON 1995
MEDICARE CODING
DOCUMENTATION CHANGES**

Be prepared for major changes in the documentation requirements for Medicare evaluation and management codes in 1995.

The Minnesota Medical Association, the Travelers Insurance Company, and Blue Cross/Medicare are sponsoring educational seminars on the 1995 documentation guidelines for Medicare evaluation and management codes, which were developed by the American Medical Association in collaboration with the Health Care Financing Administration. HCFA and other third-party payers will use these guidelines as definitive criteria when they review medical records regarding physician/patient encounter billing.

Physicians, clinic administrators, and coders are invited to attend the coding seminars. The \$85 fee covers materials, lunch, and refreshments. Participants are asked to bring their most current CPT coding book. A 1995 CPT coding book may be ordered from the MMA for \$44.68, spiral bound, or \$47.87, thumb index.

The schedule of seminars with registration times follows.

January 4, Marshall, 8:30 a.m.

January 5, Mankato, 8:30 a.m.

January 10, St. Cloud, 8:30 a.m.

January 12, St. Paul, 8 a.m. and noon

January 17, Duluth, 8:30 a.m.

January 19, Fergus Falls, 9:30 a.m.

January 31, St. Paul, 8 a.m.

Watch your mail for a brochure giving the details and including a registration form. For more information, call Vicki Westling, 612/378-1875 or 800/999-1875.

Minnesota Resolutions Are Well Received at AMA

Responding to direction from the 1994 Minnesota Medical Association House of Delegates, the Minnesota delegation to the American Medical Association introduced eight resolutions—a record number—to the AMA House of Delegates during the AMA Interim Meeting in Hawaii December 4 to 7.

The following Minnesota Resolutions were placed on the consent calendar and adopted:

Resolution 814, "Insurance Discrimination Against Victims of Domestic Violence"

The MMA asked the AMA to oppose the denial of insurance coverage to victims of domestic violence and abuse and to seek federal legislation to prohibit such discrimination. This resolution arose out of concern that victims of domestic violence and abuse are sometimes denied insurance coverage for health, life, and other types of coverage. Fear that coverage will be denied could prevent victims from reporting abuse to their doctors or to law enforcement agencies. Sixteen states now prohibit insurance discrimination against victims.

Resolution 409, "Public Education Regarding Sexual Discrimination and Harassment"

The MMA called on the AMA to continue public educational initiatives regarding sexual discrimination and harassment and to pursue educational initiatives for the media on the national level, including education of the major television networks and the Writers' Guild and the distribution of public service announcements. Minnesota delegates successfully argued that sexual discrimination continues to be a serious problem despite educational programs. Nationwide, complaints rose more than 50 percent in the first half of 1992, and there were 12,537 com-

plaints in 1993. Sexual harassment results in decreased productivity and increased sick days, causing an estimated loss of \$6,700,000 a year per average Fortune 500 company in the United States.

Resolution 811, "Data on Firearm Deaths and Injuries"

The MMA called on the AMA to support legislation or regulatory action that: 1) requires questions about firearm-related injury to be included in the National Health Interview Survey as was done prior to 1972; 2) requires the Centers for Disease Control and Prevention to develop a national firearm fatality reporting system, and 3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Resolution 809, "Development of a Glossary of Medically Acceptable Definitions for Data Collection"

The MMA asked the AMA to work with the appropriate government agencies, national medical specialty societies, third-party payers, and other groups to develop a glossary of terms related to the collection and analysis of patient care data that will be accepted as the standard for consistency and for using clinically meaningful definitions. There are no generally accepted definitions for the terms used in data collection methodology, such as "population based," or "administrative data set." Nor are there standard definitions for the types of data to be collected, such as "economic outcome" or "quality indicator," nor for the methods of analysis such as "cost-effectiveness" or "clinical appropriateness." For data collection initiatives to be credible, everyone must be speaking the same language and using standard definitions.

Resolution 404, "Support for Lawsuits Against the Tobacco Industry"

The MMA called on the AMA to support with amicus briefs the lawsuits brought against the tobacco industry in order to reduce smoking and improve patient health and, in particular, to support the lawsuit brought by the state of Minnesota and Blue Cross and Blue Shield of Minnesota against the tobacco industry. The state of Minnesota and Blue Cross and Blue Shield of Minnesota have filed a lawsuit against the tobacco industry alleging conspiracy, fraud, and antitrust violations and demanding that they be reimbursed for 40 years worth of health care costs for smoking-related illness. Smoking kills an estimated 435,000 Americans each year and among those deaths are 38,000 to 43,000 nonsmokers who contract cardiovascular disease or lung cancer from second-hand smoke.

The AMA House adopted substitute resolutions in lieu of two Minnesota resolutions.

Resolution 807, "Health Plan Restrictions on Mental Health and Chemical Dependency Treatment by Primary Care Physicians"

A substitute resolution was adopted in place of the Minnesota resolution calling on the AMA to seek the elimination of health plan restrictions on the use of appropriate mental health and chemical dependency treatment and diagnostic codes by primary care providers.

In the substitute resolution, the AMA resolves to urge third-party payers to eliminate health plan restrictions on coverage for mental health and chemical dependency treatment and to allow adequate payment and appropriate coverage for applicable diagnostic codes. The AMA also resolves to study the impact of "carve-out" programs, initiated by health care plans, on access to quality care and health care outcomes.

Minnesota delegates testified that many health insurance plans have

"carved out" and restricted mental health care to certain mental health specialty provider access points and that this practice decreases access for some patients, especially those who live in rural areas. Primary care physicians are forced to use alternative diagnostic codes to obtain reimbursement for treating patients for mental illness. In its report, AMA Reference Committee H wrote that it agreed with these concerns and was, therefore, recommending that the AMA study this issue. The report notes that existing AMA policy calls for adequate reimbursement for treating mental illness.

Resolution 712, "Clarification of the Terms 'Provider' and 'Physician' in Advertising, Contracts, and Other Communications"

In the original Resolution 712, the Minnesota delegation asked the AMA to support requirements that health care entities, when using the term "provider" in contracts, advertising, and other communications, specify the type of provider being referred to by using the provider's recognized title, which details education, training, license status, and other recognized qualifications. Substitute Resolution 712 includes this language and adds the phrase "and to support this concept in state and federal health system reform."

The MMA also asked the AMA to seek to replace the current definition of "physician" in federal law with the AMA's definition. Instead, the substitute resolution reaffirms existing AMA policy defining a physician as "an individual who has received a 'Doctor of Medicine' or a 'Doctor of Osteopathy' degree or an equivalent degree, following successful completion of a prescribed course of study from a school of medicine or osteopathy," and states that the AMA supports seeking immediate modification of the Social Security laws to change the definition of a physician to conform with AMA policy.

This resolution responds to concerns that many health plan contracts, advertisements, and other communications refer to all health

care practitioners as "providers." This vague term covers a wide variety of practitioners with different levels of education, training, and certification.

Resolution 113, "Geographic Equality in GAMC, Medicaid, and Medicare Capitation Rates"

The MMA asked the AMA to support and work aggressively for geographic equity in General Assistance Medical Care, Medicaid, and Medicare capitation rates. The rate-setting methodology used by the Department of Human Services and the Health Care Financing Administration since the inception of managed care in General Assistance Medical Care, Medicaid, and Medicare has preserved geographic reimbursement inequity in both fee-for-service and capitated systems.

With the agreement of the Minnesota sponsors of this resolution, Reference Committee A recommended changing the word "equality" in the title to "equity," and referring the amended resolution to the AMA Board of Trustees. The reference committee recommended study by the board because of the complexity of this resolution, which involves establishing public- and private-sector capitation rates and refining AMA policy related to capitation, volume assumptions, and geographic equity. The MMA delegation agreed that the resolution should be referred because of its complexity. Thomas A. Stolee, M.D., called this "the most controversial major issue to come before the AMA House of Delegates since 1987, when the MMA introduced a resolution calling on the AMA to seek federal antitrust relief for physicians."

Stolee said that Resolution 113 also has antitrust implications. Large health plans can negotiate capitated rates with the Department of Human Services, but physicians who are not part of a large plan can't do that, nor can they join together to negotiate rates because of federal antitrust laws. Support for Resolution 113 came from delegates from

Resolutions continued on page 40

Resolutions continued from page 39

states where managed care has gained a strong foothold. Opposition came from delegates who were not as familiar with the issues involved because there isn't significant managed care penetration in their states. The AMA House of Delegates accepted the reference committee's recommendation and referred this resolution to the AMA board.

Other AMA Action

The AMA Hospital Medical Staff Section introduced a resolution adopted by the 1994 MMA House of Delegates and sponsored by the Minnesota Hospital Medical Staff Section. This resolution, which calls on the AMA to oppose current regulations mandating the use of high-efficiency particulate air filter (HEPA) masks. This resolution was placed on the consent calendar and passed.

Minnesota delegate Thomas A. Stolee, M.D., wore a HEPA mask while testifying about the reasons for his opposition; the HEPA mask is an expensive and unproven safety measure that should not be required until its efficacy can be proven with appropriate epidemiological studies.

Two resolutions asking for requests for AMA action, which were adopted by the MMA House of Delegates, were not submitted to the AMA House of Delegates. MMA Resolution 1 calling for accountability of government peer review organizations and data collection services was found to be unnecessary because existing AMA policy covers this subject. MMA Resolution 34 regarding student loan payment deferment was also found to be unnecessary because AMA policy covers the issue and because the AMA recently successfully lobbied to retain the provision regarding student loan deferments in the 1994 Elementary and Secondary

Education Act. (See the December *Monitor* in *Minnesota Medicine*, page 38). MMA Resolution 52, "Definitions Related to Principal Care," was referred to the MMA Board of Trustees.

Minnesota delegates played a prominent part in the AMA meeting. Richard B. Tompkins, M.D., chair of the Minnesota delegation to the AMA, chaired Reference Committee E. Michael Achinger, representing the Medical School Section, served on Reference Committee C.

The Minnesota delegation also played a prominent role in modifying Resolution 705 to broaden the policy of the AMA to include support for state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans in addition to supporting centralized credentialing services established by state and county medical societies. • • • • •

• • • • • A N N O U N C E M E N T S • • • • •

WORKERS' COMP TREATMENT PARAMETERS TAKE EFFECT

After two years of rule making, the permanent rules requiring physicians to use treatment parameters in treating all workers' compensation patients will take effect January 4. As *The Monitor* goes to press, the final rules are scheduled to be published in the December 27 *Minnesota State Register*. The rules require physicians to follow treatment guidelines for diagnostic medical imaging, low back pain, repetitive trauma of the upper extremity, inpatient hospitalization, and surgery in treating all workers' compensation patients.

Following a hearing in August, an administrative law judge approved the Department of Labor and Industry's proposed rules subject to only minor changes. Testimony at

the hearing charged there was an inadequate level of training for some claims reviewers, particularly at certain indemnity insurance companies. Therefore, the judge required the department to develop minimum requirements for the claims reviewers who will determine appropriate treatment based on the new practice parameters. This change will be incorporated into the new rule.

Copies of the workers' compensation treatment parameters may be ordered from the Minnesota Bookstore, 612/297-3000 or 800/657-3757. For more information, contact Molly Sigel at the MMA, 612/378-1875 or 800/999-1875.

The Monitor

JANUARY 1995

• • •

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

• • •

*COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes*

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C. F.
anderson
COMPANY, INC.

CHRONIC PAIN



When the pain won't stop, turn to the **Chronic Pain** program at Gillette Children's Hospital.

The first chronic pain program for children in the region addresses headache, abdominal and musculoskeletal pain, pain associated with trauma, phantom pain, and pain secondary to serious illness.

The comprehensive treatment plan focuses on intervention, pain reduction and stress management.

Treatment options include:

- exercise
- nerve stimulation (as needed)
- hydrotherapy
- self hypnosis
- biofeedback
- massage
- systemic muscle relaxation training
- diversional activities

To refer a patient to the **Chronic Pain** program at Gillette Children's Hospital, call **229-3845**.

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

Your Future is Our Future

Join the newest member of the Fairview family - Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, our organization has joined the Fairview Health System.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Practice
Internal Medicine

OB/GYN
Urgent Care

CHISAGO HEALTH SERVICES



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



**Central Minnesota
Group Health Plan**

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

FAMILY PRACTICE/INTERNAL MEDICINE MAPLEWOOD MEDICAL CENTER

Become a member of the Group Health, Inc. physician staff at our **Maplewood Medical Center**. We have positions available for full time board certified/board eligible Family Practice/Internal Medicine physicians.

With a personable staff of eight primary care physicians, this clinic offers a solid patient base and reasonable call and hospital responsibilities.

Group Health, Inc., a progressive, managed care organization since 1957, is one of the largest multi-specialty group practices in the Midwest. Group Health offers its physicians a balanced lifestyle, excellent salaries, and a generous benefit package that includes paid malpractice.

If you are interested in starting a practice at the **Maplewood Medical Center**, please call Ann Johnson, (612) 883-5337, 1-800-472-4695 or send CV to: **Group Health, Inc.**, A Division of HealthPartners, Physician Services, Attn: Ann Johnson, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



*Group Health is part of the
HealthPartners family of health plans.*

EO/AA Employer



HealthPartners

The Board of Medical Practice Improves Its Complaint Handling System

With complaints to the BMP increasing dramatically in recent years, the board has developed a triage system to eliminate frivolous complaints and reduce its backlog.

Kent G. Harbison, J.D.

When the Minnesota Board of Medical Practice* was created in 1887, it was intended to serve basic licensing and regulatory functions. It established testing and licensure requirements for physicians, set basic medical practice standards, and performed a variety of regulatory roles, including the job of policing and disciplining licensed physicians for violations of the standards. During the past 10 to 15 years, handling disciplinary complaints has almost overshadowed the board's other functions.

Before 1985, the board received an average of 220 complaints against physicians per year. Although the number of licensed Minnesota physicians has grown somewhat since that time (now slightly less than 15,000), the number of complaints filed with the board in recent years has grown at an almost phenomenal rate—nearly 1,200 reports each year. For several years, the board attempted to manage this growth in complaints mainly by seeking legislative approval to increase the size of its staff, particularly the number of investigators from the board and those provided to the board by the Minnesota attorney general's office. Even adding more investigators, however, has not been totally satisfactory. Because it may take an average of 12 to 18 months to complete the complaint

review process, neither the persons who file the complaints nor the physicians who are the subjects of them are usually satisfied, and certainly the board and its own staff would like to expedite the process, as well.

In the past two and one-half years, the board has taken some laudable actions to deal more efficiently with the growing number of complaints. During this period, the board has made three significant changes to its complaint processing system: 1) the use of a triage process for screening all complaints against physicians, 2) the use of "corrective action" agreements as an alternative to discipline, and 3) the development of the Health Professionals Services Program, a nondisciplinary diversion program for certain impaired physicians, established by the Minnesota Legislature in 1994. (This program is discussed in detail in the September 1994 *Minnesota Medicine*, page 41.) Given the significant changes in the board's disciplinary process during the past two years, this article is offered as an update of "The Board of Medical Practice and Its Disciplinary Process" from the December 1991 *Minnesota Medicine*.

The Board's Makeup

First, a review of the board's makeup may be helpful. The board comprises 16 members, 10 of whom must be Minnesota licensed physicians with doctor of medicine degrees. One member must be a doctor of osteopathy, and the remaining five mem-

bers are lay persons. Each member must be appointed by the governor, who typically receives nominations from various professional organizations, including the Minnesota Medical Association. Two other requirements for membership on the board are significant: 1) the overall makeup of the board must reflect a state geographic balance, and 2) the 10 M.D. members must "reflect the broad mix of expertise of physicians practicing in Minnesota." All members serve terms of four years; no member may serve more than eight consecutive years.

The process for handling complaints against physicians has several components. The full-time board staff, which is managed by an executive director, handles the bulk of the initial complaint review process. The staff is often assisted by the attorney general's office, which provides legal advice through assigned attorneys and legal assistants, who handle a wide range of investigative and interviewing functions for the board. The board also designates six of its members to serve on two three-person complaint review committees. Each committee usually consists of one lay member and two professional medical members. In late 1992 the board also began for the first time referring relatively routine or minor complaints to physicians appointed by the board as "medical coordinators," who are not board members, as a part of the new triage system.

*originally called the Board of Medical Examiners

Complaints—Many Sources, Many Reasons

The board's disciplinary function usually is triggered when an outside entity or person files a complaint or similar report with the board. Most physicians probably believe that patients are the primary source of complaints. Although patients do make such reports, there are many other sources, including relatives of patients, pharmacists, the state Medicare/Medicaid program (especially regarding prescription practices), and even physicians themselves. Because the board in recent years has shown a strong interest in enforcing the statutory obligation of most physicians to report misconduct by other physicians and even themselves, more reports are being made by physicians.

Complaints reported directly by patients can probably be reduced substantially simply by better communication between physicians and their patients. A fair number of patient complaints are generated because patients are upset by or misunderstand comments from physicians. This is particularly true with respect to complaints of perceived sexual or physical overtones. Overall, the types of complaints are almost unlimited. They can range from very minor criticisms, such as long waits in a clinic, to very serious allegations, such as sexual abuse, criminal fraud, or alcoholism. Since the mid-1980s, the most common allegations filed against physicians have included inappropriate prescribing practices, boundaries issues (physical/sexual contact), improper management of medical records, and alcoholism or other forms of chemical dependency.

The Minnesota Medical Practices Act sets out more than 20 different statutory classifications of misconduct justifying some type of disciplinary sanction. Some of these categories are quite narrow, such as the revocation of a physician's license by another state or a physician's conviction for certain types of criminal offenses. Other categories of misconduct are quite broad, such as "engaging in unprofessional conduct."

As noted above, physicians may also be disciplined for failure to report their own violation of any part of the Medical Practices Act. The board also has the power to discipline physicians for not reporting personal knowledge of misconduct by another physician. No report is required, however, if the knowledge was obtained during a physician-

"A physician is well-advised to take seriously all medical board investigations."

patient relationship if the patient is the reportable physician, so long as the treating physician "successfully counsels" the other physician to terminate the conduct in question. Finally, the board can discipline physicians who are already the subject of investigation if they refuse to "cooperate" with the investigation. There is little guidance in the law regarding the definition of "cooperation," but refusal to cooperate surely would include a physician's refusal to submit to an interview or produce records in response to the board's investigative requests.

Triage Screens Complaints for Severity

All complaints, regardless of their type, are now processed through the board's triage system, which was implemented in the fall of 1992. Misconduct allegations are initially analyzed by board staff members and one of the medical coordinators (currently three) retained by the board to assist with this program. Most complaints are then sent to other board staff members or investigators at the attorney general's office to obtain information pertinent to the subject of the complaint. Collection of such information may include asking the physician to provide a written response to the complaint or submit to a personal interview and often will

also entail the production of medical records, consultants' reports, and other relevant documents. Depending on the severity and urgency of the complaints, this information gathering may take many weeks or months to complete.

All of this information, which at this stage is confidential and not available to the physician, is given to one of the two board complaint review committees to evaluate. The complaint review committee acts initially as a screening mechanism without any personal contact with the physician. It may choose at this early point to dismiss the complaint without any further proceedings, or it could conclude that discipline is justified and make a recommendation accordingly to the board. Another option is to have the complaint investigated further for more complete consideration during a conference with the physician before the complaint review committee (discussed below) or one of the medical coordinators. The triage panel may believe that a physician has technically violated the Medical Practices Act but in a relatively minor manner that does not justify discipline. In such a situation, the panel may refer the report to a medical coordinator, who would schedule an informal one-on-one meeting with the physician to discuss the complaint at the board offices. Physicians are generally notified of these meetings by telephone rather than letter but are usually expected to travel to the board offices in St. Paul for the meeting.

Physicians asked to meet with a medical coordinator probably can conclude that the board has tentatively determined that the complaint is relatively minor and not likely to result in discipline. The primary purposes of the medical coordinator meetings are to confirm whether the tentative conclusions are accurate and to provide a subtle message to the physician to be careful to avoid future complaints.

Although the medical coordinator sessions usually result in complaint dismissals, the medical coordinator has the authority to refer complaints back to the complaint review committee for more formal review

and consideration. Thus, physicians should be well prepared and are wise to be accompanied by an attorney, to which they are entitled. The meetings usually last no more than 30 to 45 minutes.

The use of the triage approach and the medical coordinator sessions was intended to help the board eliminate many of the hundreds of complaints on file at any given time. This approach has been somewhat successful, but there are so many complaints on file with the board that it still often takes at least nine to 12 months to resolve them, and in some cases, much longer. Nonetheless, the recent changes in the process have begun to bear fruit. At the end of fiscal year 1991, the board had 1,844 unresolved complaints on file. By the close of fiscal year 1992, the number of pending complaints had dropped to 1,295, and as of April 1994 the total was 990. These numbers are still quite large, but the trend is promising.

The board usually processes the more serious complaints through the complaint review committee conference system. This does not mean that physicians directed to appear for a conference with a complaint review committee should assume they are likely to be disciplined. In fact, the majority of all complaints ultimately are dismissed without any public record.

Complaint Review Committee Conferences

The complaint review committee conference is somewhat more formal than the medical coordinator meetings and usually covers issues or subjects of greater concern. The basic purpose of the conference is to give the committee members and the physician a fuller opportunity to speak directly to one another regarding the accusations of misconduct and to ensure that the board's decision is based on more complete information than that presented during the investigative stage of the process.

Physicians are entitled to be represented by attorneys at these conferences, and again, such representation is wise.

Physicians who are directed to appear for a conference with a complaint review committee are usually given written notice approximately one month before the conference. Conferences are held at the board offices in St. Paul, and the board seldom agrees to reschedule them.

A conference notice typically identifies the factual allegations against the physician and describes the physician's legal rights and responsibilities. The notice also refers to the specific sections of the Medical Practices Act that will have been violated if the allegations of misconduct are true. The notices state that the reports constitute only "allegations," and that the board has not made any prejudgments regarding their validity. The purpose of the conference is to help the complaint review committee make that decision after questioning the physician.

Because the Medical Practices Act provides that all parts of the investigative and predisciplinary determination are confidential, the physician is not entitled to know the source of the complaint. If the subject matter of the complaint necessitates the review of patient records, the board usually will issue a subpoena for the records, which it is entitled to do under the Medical Practices Act. Sometimes the board will also provide the physician with a statement by the patient authorizing the physician to release the records to the board.

In some cases, it is not possible for the physician to respond adequately to a complaint without knowing the identity of the patient involved. For example, if a physician is questioned regarding prescribing practices over a period of years, the board usually focuses on prescriptions to specific patients on specific dates. In fact, conference notices in prescribing cases may contain many pages of information for each patient's prescriptions, such as date of issue, type of prescription, and dosage amounts. However, unless the identity of the patient is critical to the physician's defense of the allegations, the board usually will not disclose it.

The confidentiality requirement has a twofold purpose. First, if the

source of a complaint knows that his or her identity will not be disclosed to the physician, the complainant will be more willing to submit a complaint. Second, it is unfair and a breach of privacy to disclose publicly allegations that may not constitute a reason for discipline, especially since most of the complaints are dismissed.

The conference before a complaint review committee usually lasts about one hour, depending on the number of allegations and their seriousness. The conference is tape recorded and closed to the public. The only persons present besides the physician, the physician's attorney, and the three committee members are the committee's attorney and usually four to five other board staff members, including the executive director. In most cases, the committee meets for an entire day, scheduling several separate physician complaint conferences that day.

The conference is usually a question-and-answer session between the physician and the three members of the committee. The committee chair usually begins the conference by asking specific questions related to the allegations contained in the Notice of Conference. Other committee members also usually ask questions and, of course, the physician is the person expected to answer. Occasionally, a consultant may assist the committee in asking the questions, especially if the allegations center on a specialized practice area that may be beyond the expertise of the individual committee members. (Sometimes the committee will rely on a report from a consultant who previously reviewed the allegations and the medical records to help determine the validity or seriousness of the allegations.)

The committee's attorney seldom asks any questions at all; those who do ask questions usually limit them to one or two. The committee usually gives physicians and their attorneys an opportunity to make closing statements or other comments to ensure that the physician's side of the story is presented. Although it is not generally appropriate for the physician's attorney to answer many committee questions, the attorney can help clar-

ify issues and questions for the physician.

At the end of the questioning, the committee usually excuses the physician (and attorney) from the conference room while it discusses the allegations and evidence. The committee then promptly informs the physician of its recommendation, which is almost always adopted by the full board.

Board Options for Resolving Complaints

The decision by the complaint review committee usually comes in one of five forms.

Dismissal: It may dismiss the complaint, meaning that the case is closed and confidentiality maintained. (Again, the full board must approve complaint review committee decisions, but it is rare that such decisions are not accepted.)

Further investigation: The committee may send the case back for further investigation or consideration by consultants, especially when the committee is concerned that the evidence is incomplete or believes an expert opinion from a specialist is needed.

Disciplinary sanction: The committee may recommend some type of disciplinary sanction against the physician. These sanctions may range from a simple reprimand to the revocation of a physician's license. Revocation is quite rare, but the board has almost unlimited discretion in fashioning other types of remedies or sanctions, including requiring the physician to attend refresher courses on particular subjects (such as prescribing practices or patient boundaries), assessing monetary fines of up to \$10,000 per violation, and placing other conditions on a physician's license.

Minnesota courts have made it clear that the primary purpose of board disciplinary orders is to protect patients and the public at large rather than to punish individual physicians. In other words, the board should not discipline a physician unless it is convinced that the discipline will help protect and serve patients and the public generally.

Corrective action agreement: A fourth option available for a complaint review committee is "corrective action agreements." The corrective action remedies are settlement agreements between the board and a physician whereby the physician agrees to make certain changes in his or her practice or to take some type of refresher course in exchange for the board's ultimate dismissal of the complaint. Although corrective action agreements are technically part of the board's public files, they are not considered forms of discipline and are not reported separately by the committee to the board. They are also not reported to the news media, whereas disciplinary remedies are. The use of corrective action agreements represents another effort by the board to expedite the investigative process and to help eliminate some of the complaint backlog. The board began using corrective action agreements when it adopted the triage system.

As *Minnesota Medicine* goes to press, the board's complaint review committees have entered into corrective action agreements in 19 cases: seven for chemical dependency or mental illness, nine for competency (including prescribing practices and record-keeping), and three for patient boundaries.

Referral program: The fifth and most recent remedy is the "Health Professional Services Program" created by a 1994 statute. The board may refer certain impaired physicians to a treatment and monitoring program as an alternative to discipline (see September article, page 41).

The Physician's Options

Because the committee's decision at the complaint review conference is often a recommendation for the full board, the physician has the option of accepting or rejecting the recommendation. If the physician chooses to reject a recommendation of discipline, he or she has the right to a full evidentiary contested case hearing before a state administrative law judge. This hearing is quite similar to a court trial and enables the physician to present his or her own evi-

dence and witnesses and to cross-examine the opposing witnesses. At this stage of the proceeding, the physician also has the opportunity to learn the identity of the complaining person or persons and has access to some of the board's previously confidential files affecting the case.

Although the right to an administrative contested case trial seems attractive, it is not necessarily what it may appear. The decision of the administrative law judge is simply a report of the findings of fact and legal conclusions based on the evidence presented during the trial or hearing. The judge does not make the final decision regarding whether or not discipline is to be imposed; rather, that decision remains with the full board after it receives the report and transcript of evidence from the administrative law judge. Consequently, so long as the board concludes that a physician has engaged in some type of misconduct or violation of the Medical Practices Act, regardless of how significant or insignificant, it still has the authority after an administrative trial to impose public disciplinary sanctions against the physician.

A physician also has the right to challenge the board's final decision through an appeal to the Minnesota Court of Appeals, but the courts have often shown great deference to the board's decisions. The courts' attitude seems to be that, so long as the board's decision is reasonably supported by the evidence in the administrative law judge's report, the courts will not set aside a disciplinary decision based on that evidence. This is true even if the court itself might subjectively believe that discipline is not justified.

Given these factors and the time and expense necessitated by an administrative contested case hearing, physicians rarely challenge board decisions through a contested case hearing or judicial appeal.

Reporting Requirements

The board is required by law to periodically publish a summary of all disciplinary decisions against physicians to the Legislature and the news media. Furthermore, all disciplinary

decisions must be reported to the National Practitioner Data Bank in California, which was established several years ago as a national record center and monitoring system for physicians throughout the country. State licensing boards, hospitals, and certain other entities may have access to the Data Bank records to determine whether physicians have been disciplined or otherwise had their licenses restricted.

There are two exceptions to the public reporting requirement concerning medical board decisions. Discipline imposed because a physician is impaired and unable to practice medicine with reasonable skill and safety is specifically exempted by state law from being reported to the news media, although the decision is in the board's public files and available for inspection. This is more fully explained in the September article on the Health Professionals Services Program. Also, corrective action agreements between the board and physicians are not reported to the news media because they do not constitute disciplinary decisions. These agreements are, however, part of the board's public files. (A pending or dismissed complaint is not reported or otherwise open to the public.)

No Statute of Limitations

Unlike most other legal claims, medical board disciplinary investigations and remedies are not restricted by a statute of limitations. The board has the power to investigate and discipline physicians for alleged misconduct occurring even 10 or 20 years in the past. In fact, it is not unusual for the investigation and the conference with a complaint review committee to be held one or two years after the complaint has been filed with the board. These facts definitely raise the possibility of complaints reported at a time when witnesses and other evidence are no longer available or the witnesses' memories of the case have greatly faded.

Perhaps the most extreme illustration of the dilemma potentially created by the absence of any time limitation arises in the context of patients who have received therapy for emotional, psychological, or oth-

er mental illnesses. For example, a patient may allege that a physician violated professional boundaries in the physician-patient relationship 15 years before the patient's memory was refreshed so that he or she could recall the violation. Furthermore, the patient hypothetically could wait another two to three years before reporting the allegation to the Board of Medical Practice.

Conclusion

In light of all these factors, a physician is well-advised to take seriously all medical board investigations. Even though most board complaints are dismissed without any public record, there is too much at stake for a physician to participate in the process without careful preparation and advice.

The board has recognized the problems created by the growing number of complaints lodged with

it—problems for physicians, patients, and the board itself. During the past three years the board has attempted to eliminate from the disciplinary system frivolous complaints and to expedite the processing of all reports. In the meantime, it attempts to strike a balance between the perception in some quarters, including the news media, that it is too lenient with "bad" physicians and the perception among many physicians that it is unnecessarily accusatory and punitive. Considering the competing interests and conflicting opinions, the board is not likely ever to satisfy everyone.

MM

Kent Harbison is an officer and shareholder at Fredrikson & Byron and works in the firm's Litigation Department handling a variety of general commercial, health law, banking, probate, and employment cases.

Creative solutions for all your health law problems



Leonard, Street and Deinard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

LETTERS

(continued from page 3)

ethics committees, and an environment supportive of living wills can clearly help a hospital and its medical staff deal with the difficult and often agonizing decisions related to death and dying.

I invite readers with comments to write me at 9375 Pierson Lake Drive, Chaska, MN 55318.

*Scott M. Jensen, M.D.
Family Practitioner
Chair, Ethics Committee
Ridgeway Medical Center
Waconia, Minnesota*

Editor's Note: Watch for the February *Minnesota Medicine*, which will address a number of issues related to death and dying.

The Caduceus Has Modern-Day Relevance

I recently read the article by Paul Frett in the October *Minnesota Medicine* called "Medicine's

Identity Crisis Revealed: The Asclepius vs. the Caduceus," which states that the staff of Asclepius (a rough, knotty staff with a single snake coiled around it) is the true medical symbol—not the caduceus (a winged staff intertwined by two snakes). I would like to share some thoughts on the matter.

I was educated to think of Asclepius as the founder of medicine along with Hippocrates. However, in the present context, I believe the caduceus may be more symbolically representative of modern medicine and the health professions.

Asclepius is the Greek god of healing, but his healing could bring the dead back to life. Hades, god of the dead, complained to Zeus that Asclepius was cheating the kingdom of the dead; Zeus agreed, and he killed Asclepius with a thunderbolt. Do we want to be associated with bringing back the dead? In medicine, we deal with relief of pain and suffering, and we may prolong life or delay death, but we cannot prevent death.

The snake universally symbolizes healing, going back to the days of the Egyptians. However, the single snake of the Asclepius may be an outdated concept today. It symbolizes singleness, which in ancient and former times stood for masculine power. Before the 20th century, the feminine was degraded or not given much credence. We live in a feminine-masculine world today, where the feminine is generally considered more the caretaker than the masculine.

This duality aspect of humanity is universally accepted by cultures around the world, as evidenced in the Eastern idea of yin and yang, the concepts of self and the shadow, the sun and the moon, and light and dark. Two snakes coiling around a central staff symbolize the unity of the feminine and masculine in each person, as theorized in Jungian psychology. The intertwined snakes also can symbolize the double-helix configuration of DNA, the building block of life.

The caduceus is associated with Mercury, the Roman messenger of the gods (Hermes in Greek mythology). As physicians, we deliver the message of health. Yes, Mercury and Hermes were considered crafty and deceptive, but these are all old connotations.

The wings atop the caduceus can be thought of as "angelic," lifting patients to higher good, i.e., health.

As a gynecologist, I have learned much from female patients. I am interested in hearing on this matter from our female colleagues.

The caduceus has come to symbolize the medical profession today and is accepted by the general public. Both the caduceus and the Asclepius stand for healing, but I believe the caduceus is more relevant today.

*Jerome J. Scherek, M.D., F.A.C.O.G.
Obstetrician/Gynecologist
Anndale, Minnesota*



**Hands
are *not*
for hitting.**

Domestic violence is preventable.



Created by the Minnesota Coalition for Battered Women - 612/646-6177 VTDD.



Disability income insurance that pays benefits. Come illness, injury or good health.

Protect the earnings you work
so hard for with our Preferred
Professional policy:



- Non-cancellable
- Guaranteed to age 65
- Pays benefits for total and partial disability
- Automatic coverage increases can be built in.



And our optional premium refund benefit
will return to you up to one-year's or
three-year's premium payments every fifth
year if you're fortunate enough to stay
healthy!*

Contact us today for a complimentary,
no-obligation disability needs analysis.



FALK LIBRARY OF THE HEALTH SCIENCES
UNIVERSITY OF PITTSBURGH
PITTSBURGH, PENNSYLVANIA 15261

*One dollar is subtracted from your refund for every dollar in claims benefits received in the previous five years

Minnesota Physicians Insurance Agency

3433 Broadway St., NE

Suite 375

Minneapolis, MN 55413

Tel: (612) 623-2860

Fax: (612) 623-2855

The Paul Revere Life
Insurance Company



Join Paul Revere, and ride with the winner.

People and Places Making Medical News

People

Health Commissioner Resigns

Minnesota Health Commissioner Mary Jo O'Brien is resigning effective January 20, 1995, according to an announcement by the governor's office in late November. O'Brien was instrumental in designing and implementing the legislation that created MinnesotaCare, the state's health plan for low-income uninsured persons. O'Brien, former director of legislative relations for the Minnesota Medical Association, has said she intends to pursue other health care-related job opportunities.

Health Commission's Executive Director Resigns

The Minnesota Health Care Commission announced in December the resignation of its executive director, Michael Scandrett, also an architect of the MinnesotaCare legislation. He is resigning to pursue other professional interests and to spend more time with his family.

Scandrett's role as executive director began when the Minnesota Health Care Commission was established under the 1992 MinnesotaCare legislation. The commission's assistant director, David Haugen, has been appointed acting executive director.

Children's Health Care Medical Director

Children's Health Care has named Phillip Kibort, M.D., medical director of ambulatory services for its Minneapolis, St. Paul, and West (Minnetonka) campuses.

Kibort, medical director for medical services at Children's-St. Paul, is also an active staff member at Children's-Minneapolis and was chief of staff there in 1990. He has served as medical director of ambulatory services at Children's-

St. Paul since 1992. He has left his private practice in gastroenterology to take on this expanded role.

American Cancer Society Award and Appointments

The American Cancer Society presented in November its Humanitarian Award to Oliver H. Beahrs, M.D., professor of surgery emeritus at Mayo Medical School and an American Cancer Society Honorary Life Member. He received the award for his "great devotion to and deep concern for cancer patients, their loved ones, and the entire community; for a distinguished career as the leading surgeon at the Mayo Clinic and outstanding service to the American College of Surgeons; for contributions to cancer control through excellence in writing and publishing; and for service to all walks of life while establishing a nationally and internationally recognized leadership role in the surgery field."

In October, the Minnesota division of the American Cancer Society announced the following new officers for 1994-95: president, Kirk Simpson, M.D., a family physician; president elect, Richard Elzay, D.D.S., dean of the University of Minnesota Dental School; chair of the executive committee, John Kenefick, an attorney with Briggs and Morgan; treasurer, Stephanie Prem, a banking officer with Norwest Capital Advisors; secretary, Char Jorgensen, an administrative assistant with Blue Cross and Blue Shield of Minnesota; and chair of the board, Patti Swanson, R.N.

Places

New AIDS Consortium

A team of three Twin Cities health care organizations has created the AIDS Research Consortium Twin

Cities (ARCTC), a collaborative effort to learn more about assessing, treating, and managing care for persons infected with HIV. The consortium brings together the following four physicians at three sites: Keith Henry, M.D., St. Paul-Ramsey Medical Center; Ron Schut, M.D., Hennepin County Medical Center; and Paul Carson, M.D., and Scott Strickland, M.D., Park Nicollet Medical Center. The three organizations combined research efforts to gain access to persons with HIV and to attract major pharmaceutical companies looking for research teams.

Last year, the organizations collaborated on three studies involving a new drug, Delavirdine. Results of the studies are pending. The groups are also starting research on a proteinase inhibitor called Ro 31-8958.

Minnesota Hospitals in Top 100

Seven Minnesota hospitals are among the country's top 100, according to a 1993 analysis of almost 4,000 acute care hospitals published in the November 14 *Modern Healthcare*. They are St. Marys Hospital of Rochester, Rochester Methodist, St. Mary's Medical Center in Duluth, United Hospital in St. Paul, Mercy Hospital in Coon Rapids, HealthEast St. John's in Maplewood, and St. Cloud Hospital. The analysis, based on eight measures of clinical, operational, and financial performance, concluded that U.S. hospitals would save \$21.6 billion, trim patient stays by a day, lower mortality rates by 17 percent, and lower complication rates by 14 percent, if they all performed at the level of the top 100 hospitals. The study was conducted by HCIA, a Baltimore-based health care information company, and Mercer Health Provider Consulting in New York.

St. Luke's Cancer Program Approved

The American College of Surgeons Commission on Cancer has granted three-year approval to the cancer program at St. Luke's Hospital in Duluth and elevated the program's status from a community hospital cancer program to a community hospital "comprehensive" cancer program, according to Phillip A. Alioto, president and chief executive officer.

St. Luke's Cancer Program is one of eight in Minnesota to receive this distinction, and the only commission-approved program in Duluth. The Commission on Cancer sets standards for approval of hospital and free-standing cancer programs.

New Apple Valley Clinic

Cedar Ridge Medical Associates, a new Fairview family medicine clinic, opened in Apple Valley in November. The new primary care practice, intended to serve persons living in the Apple Valley-Lakeville area, is staffed by three family medicine physicians: Medical Director Mary Homan, M.D.; Jeffrey Michell, M.D.; and Mark Rieb, M.D. The physicians will have hospital privileges at Fairview Ridges Hospital in Burnsville. The clinic, also staffed by a registered nurse, a patient care coordinator, and a radiology technician, features on-site lab and x-ray services.

HCMC Awarded Grant for Alternative Medicine

The National Institutes of Health has awarded the Minneapolis Medical Research Foundation (MMRF), a unit of Hennepin Faculty Associates, an \$840,000 grant to research alternative medicine treatments for substance abuse and related problems. The studies, led by Thomas Kiresuk, Ph.D., and Patricia Culliton, M.A., Dipl. Ac. (diplomat of acupuncture) at Hennepin County Medical Center's alternative medicine clinic, will focus on mind/body control therapies like relaxation and self-

hypnosis; ethnomedicine, such as Native American healing; and bioelectromagnetic therapies, such as electro-acupuncture. The studies will be conducted over the next three years.

MMRF competed with 30 applicants nationwide to receive one of two grants, according to James Bryant, a spokesperson for the NIH's Office of Alternative Medicine. The other grant went to Seattle's Bastyr University, where researchers will study alternative treatments for HIV.

Socioeconomics

Surplus Projected for MinnesotaCare

State officials now project a \$48.9 million surplus for MinnesotaCare by 1997—good news considering earlier projections called for a \$45 million deficit, according to the state Finance Department. Fewer people have enrolled in the program than originally expected. Only 1,336 adults without children who became eligible have signed up since October 1; about 5,000 were expected to sign up.

The Minnesota Health Care Commission has been considering recommendations for how to meet the projected deficit, such as taxes on cigarettes and lottery tickets. "This eases the burden a bit," said Tom Swain, commission chair. However, commission leaders emphasize that the surplus will shrink as enrollment increases.

District Memorial to Join Fairview

District Memorial Hospital in Forest Lake has joined Fairview Health System effective January 1. Under the terms of their agreement, Fairview will operate the hospital and related services as a division of Fairview. District Memorial Hospital Chair Yvonne Henrich said the board believes the affiliation with Fairview is in the best interest of the patients, staff, and community. She said it provides District Memorial staff with

continued opportunities for employment, while allowing the hospital input on the new regional medical center that Fairview and Chisago Health Services plan to develop on I-35 within the next few years.

Employers Association Chooses Medica

The Employers Association, a coalition of about 4,000 small employers with fewer than 1,000 employees each, has chosen Medica to provide health care coverage to member employees. The three- to five-year contract was awarded to Medica over HealthPartners and Blue Cross and Blue Shield of Minnesota. In the contract, Medica agreed to an average of no premium increases for some companies in 1995, and maximum premium increases of 6.5 percent in 1996 and 6 percent in 1997.

The Employers Association had previously contracted with Prudential Insurance Co., which announced this summer that it was leaving the Twin Cities market.

St. Cloud Group Forms First CIGN

Central Minnesota Group Health Plan of St. Cloud has become Minnesota's first community integrated service network, a new managed care designation created in the 1994 MinnesotaCare legislation. The health plan, which serves more than 21,000 members and has more than 250 employees, offers health coverage through clinics in Foley, Little Falls, Albany, Sauk Centre, and Paynesville. It is a subsidiary of Group Health, part of HealthPartners.

American Family Ending Medical Business in Minnesota

American Family Insurance will no longer be providing health insurance in Minnesota because of the "punitive regulatory environment established by the MinnesotaCare legislation," said Executive Vice President James Klokner. About 8,600 policyholders and their dependents will have to find new

medical coverage when their policies expire.

American Family was the fourth-largest individual health insurance carrier in Minnesota, after Blue Cross and Blue Shield, State Farm, and MidAmerica.

MDH Training EMTs to Treat Children

The Minnesota Department of Health is launching a new training program designed to help out-of-hospital emergency medical personnel meet the special care

needs of children. It is training about 192 medical personnel throughout the state to be instructors for the program, who will then train emergency medical technicians and first responders to handle medical emergencies involving children.

Younger emergency medical patients—especially very young children—can present unique problems for the emergency care responder. Emergency personnel need child-sized equipment, such as airway tubes, oxygen masks, blood pressure cuffs, and cervical collars, as well as prepackaged medications in children's dosages.

"Vital signs like blood pressure, heart rate, and respiration need to be interpreted differently in a child than they would be in an adult," said Michael Wilcox, M.D., chair of the Emergency Medical Services for Children Steering Committee. "Providers also need to be aware of which hospitals and emergency care facilities are best prepared to receive and treat younger patients."

The training program is funded through a federal grant that runs through September 1995. MDH officials hope to renew the grant for an additional year. About six training classes will be held in each of the state's eight emergency medical services regions during the coming year. Eventually, about 2,200 emergency care providers will be trained statewide.

NHN, Park Nicollet Start Managed Medicaid Program

NWNL Health Network, Inc. (NHN), HealthSystem Minnesota, Park Nicollet Medical Center, and Methodist Hospital have contracted to offer a new managed Medical Assistance (MA) and General Assistance (GAMC) program called Park Nicollet Care. The program is offered under NHN's contracts with Minnesota for prepaid MA and GAMC services and is available to eligible persons covered by MA and GAMC in Dakota, Hennepin, and Scott counties. The program enables recipients who select the Park Nicollet Care plan

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- **Family Practice**
- **General Surgery**
- **Obstetrics/Gynecology**
- **Internal Medicine**
- **Otolaryngology**
- **Occupational Medicine**
- **Urgent Care**



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

612-885-6224

1-800-842-6469



to go to Park Nicollet clinics, Methodist Hospital, and affiliated providers.

The plan is a capitated arrangement through which HealthSystem Minnesota, Park Nicollet, and Methodist bear the financial risk for health care costs. NHN provides a full range of administrative services for Park Nicollet Care, including claims processing, utilization review, and quality assurance.

Pure Community Rating Would Jeopardize Health System Reform

Approximately 64,000 Minnesotans currently receiving health care coverage through small businesses would need to purchase different coverage or go without health care insurance if Minnesota adopts a "pure community rating" system, according to Commerce Commissioner James E. Ulland. Research commissioned by the Minnesota Department of Commerce shows that the number of employees covered will drop in companies that have a majority of younger workers if a pure community rating system is adopted because such a system would dramatically increase health insurance premiums for these firms, said Ulland.

The study examined the small employer market, which is identified as companies from two to 29 employees. About 285,000 Minnesotans currently receive their health care coverage through this market.

The study, conducted by Milliman & Robertson of Bloomington, predicts a 10 percent increase in average premium rates above the normal trend increase and a projected decline in coverage of 22 percent using the 1994 legislative timetable for the implementation of community rating. The projected decline in coverage is 23 percent using the 1992 timetable.

Commissioner Ulland urged the Legislature to take these findings into account when resuming debate on MinnesotaCare initiatives in the 1995 session.

Mayo Forming Affiliations

The Mayo Clinic has announced plans to affiliate with three different groups in southern Minnesota and Wisconsin. The first is Albert Lea Regional Medical Group, a 36-physician multispecialty clinic that

provides health care services through offices in Albert Lea, Alden, Kiester, New Richland, and Wells, Minnesota, and Lake Mills and Northwood, Iowa. The clinic will be renamed Albert Lea Clinic and will become part of

WE PRACTICE LAW
SO YOU CAN
PRACTICE
MEDICINE.

CALL US FOR ALL YOUR HEALTH
CARE RELATED LEGAL NEEDS.

JOEL H. GREEN, JAMES S. MATTHEWS, SHEVA SANDERS

LINDQUIST & VENNUM

A Professional Limited Liability Partnership
4200 IDS CENTER • MINNEAPOLIS, MN 55402 • 612-371-3211

the Mayo Health System.

The 26-physician Austin Medical Clinic and the 108-bed St. Olaf Hospital in Austin, Minnesota, also have agreed to affiliate with Mayo Clinic. Shortly after the affiliation is complete early this year, Austin Medical Clinic, with offices in Austin, Adams, Blooming Prairie, and Grand Meadow, Minnesota, and St. Olaf Hospital will integrate further to create a single medical center, called Austin Medical Center. The combined center will become part of Mayo Health System. Timothy Johnson, M.D., family practice specialist, will serve as president.

Mayo also has agreed to pursue negotiations with Skemp Clinic and Franciscan Health System to affiliate. As *Minnesota Medicine* goes to press, the agreement is not complete, but the groups plan to develop an integrated system based in La Crosse, Wisconsin.

Rates, Trends, Data

Medical Inflation Lowest in Seven Years

Medical inflation in the United States for 1993 was 7.8 percent for 1993, the lowest in seven years. The Health Care Financing Administration reported that Americans spent an average of \$3,299 per person on health care in 1993—\$205 more than in 1992—bringing total health care spending to \$884 billion. It was the third-lowest increase since 1960.

Nonetheless, Americans spent about \$1 of every \$7 they made on health care—more than any other country in the world. Health care accounted for 13.9 percent of the gross domestic product, up from 13.6 percent in 1992.

Innovations

Mayo to Study Alternative to Heart Transplant

The Mayo Clinic is participating in a 20-clinic study to test a procedure that involves taking a portion of the latissimus dorsi muscle from

the back, wrapping it around the heart, and electronically training it to help the heart pump blood. The procedure, known as cardiomyoplasty, has been performed on about 420 patients worldwide since it was invented in Paris in 1985. Mayo Clinic will perform the procedure on 12 patients a year for two years. The FDA will then study the results for an additional three years before it decides whether to approve the procedure for general use. Mayo is the only clinic in the Midwest involved in the study.

The cost of the procedure is about one-half to one-third the cost of heart transplants, experts say. The lifetime cost comparison is even better because patients do not need continuous drug therapy to prevent rejection, as they would with a heart transplant.

Medical Research

Expensive Heart Test Not Needed for Some Patients

An expensive nuclear cardiology test is not necessary to help physicians identify severe heart disease in patients with a normal at-rest electrocardiogram, according to a Mayo Clinic study published in the December *Annals of Internal Medicine*. "In predicting severe heart disease, we found that talking to the patient and doing a regular treadmill test was just as effective as using more expensive imaging technologies," said Timothy Christian, M.D., Mayo cardiologist and principal author of the study.

Mayo researchers examined 411 patients with normal at-rest electrocardiograms. Each of the patients was classified into a heart-disease risk category by undergoing exercise electrocardiography, which Medicare reimburses at \$89, and nuclear thallium 201 imaging, which Medicare reimburses at \$700.

Researchers found that using the more expensive test resulted in only 3 percent of patients being

reclassified regarding their predicted risk for severe heart disease.

"Based on 1992 Medicare data, we estimate that \$30 million could be saved annually if this approach were followed," said Christian. He said the patients in the study were followed for four years and the overall outcome was excellent, probably because the patients had normal resting electrocardiograms.

Most U.S. Asthmatics Not at Risk of Dying

The death rate for U.S. asthmatics without other lung problems is no higher than it is in the general population, say Mayo Clinic researchers. According to their study published in the December 8 *New England Journal of Medicine* the only asthmatics with a higher chance of dying are those with emphysema and chronic bronchitis, two diseases usually associated with cigarette smoking.

Mayo researchers followed 2,499 Olmsted County asthmatics for an average of 14 years, following some for up to 29 years. Of the 140 deaths recorded during the study, only four were asthma-related. The report's lead author, Marc Silverstein, M.D., believes the results apply to most areas of the United States, even though most people in the study were white and largely middle class.

Bone Marrow Transplant Patients Lead Productive Lives

Quality of life among allogeneic bone marrow transplant patients does not diminish in the long term following surgery, according to researchers at the University of Minnesota Hospital. Their research shows that the procedure is not only curative, but that the result for patients is a return to productive lives.

"They are working, living independently, and, in general, feeling good," said Stella M. Davies, M.D., Ph.D., assistant professor in the university's Department of Pediatrics and the study's lead researcher. "Based on

this study, I feel more comfortable recommending a bone marrow transplant because I can more fully justify it. Patients and their families are entitled to know not just that they have a good chance for survival, but that they will not suffer unduly as a result of the treatment."

The study compared related (RD) and unrelated donor allogeneic transplant (URD) recipients. Unlike most studies, it asked transplant recipients to assess their quality of life themselves; most studies get these results from physicians. The study was also unusual because most studies have not explored the quality of life among URD patients, whose convalescence tends to be longer and involve more complications than in RD cases, said Davies.

The study involved 31 URD recipients and 52 RD recipients as controls, all of whom had survived for at least two years following treatment at UMHC. Patients, or parents in the case of children

under 18 years, were queried by trained telephone interviewers. Overall, there were no significant differences between the URD and RD recipients in their self-reported quality of life, according to Davies. Both groups generally judged their quality of life to be good, with only one URD and six RD recipients unable to carry on normal activity. Of the 31 URD recipients, 28 were in full-time work or attending school at a level appropriate for their age. Further, only two RD and no URD patients had been limited for more than three months in any kind of physical activity covered, including playing sports, carrying groceries, and walking uphill.

Smoking Cessation Slows Cancer

Quitting smoking can slow chronic lung disease significantly, according to a five-year, \$49 million Lung Health Study sponsored by the National Heart, Lung and Blood Institute. The study tested the effectiveness of antismoking

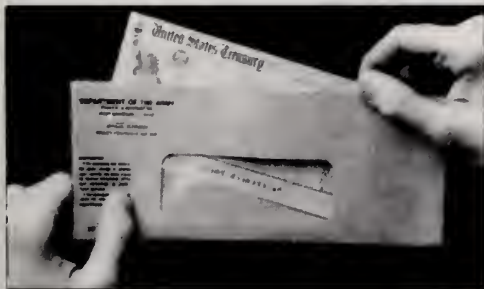
programs on people who have early signs of chronic lung disease, the fourth-leading cause of death in the United States.

The study assigned 5,887 people aged 35 to 60 with chronic obstructive pulmonary disease (COPD) to one of 10 medical centers (including Mayo Clinic) and placed some in aggressive antismoking programs; others received more common forms of care. Participants had smoked an average of 31 cigarettes a day and had been smoking for an average of 30 years.

After five years, those who quit smoking were losing lung function at approximately the normal rate, but the smokers worsened much faster. What this means, said Thomas Kotke, M.D., a cardiologist and preventive medicine specialist at the Mayo Clinic, is that former smokers with COPD "probably still are going to die of lung disease, but it may be 10 or 15 years from now, not next month or next year." MM

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor.

**CALL COLLECT CPT. RICK OTTO
612-854-7702**

**ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®**



**Associate Director,
Undergraduate Pre-clinical Curriculum
University of Minnesota, Duluth
School of Medicine**

is seeking to fill a new position in its expanding Department of Family Medicine. This faculty position is full-time, non-tenured, (administrative & professional) with 55% time committed to school-related activities and 45% time for private practice. Faculty rank will be based on qualifications and experience. The primary responsibility is coordination and evaluation of the undergraduate pre-clinical medical curriculum for years 1 & 2. Teaching opportunities in other undergraduate and family practice residency programs are available.

Applicant must be a graduate of a U.S. accredited training program with an MD or DO degree, board certified or eligible preferably in Family Medicine, although other primary care specialties and Preventive Medicine will be considered. Practice experience, teaching experience and/or academic administrative experience are preferred. Candidate should be willing to participate in a part-time private practice and be eligible for licensure in Minnesota.

To apply, please submit a letter of interest, a curriculum vitae and three reference names to: **Malcolm L. McCutcheon, MD, Chair, Family Medicine Search Committee, UMD School of Medicine, 10 University Drive, Duluth, MN 55812 (phone: 218/726-7918 or e-mail: mmcutch@d.umn.edu). Applications accepted thru 2/28/95.**

The University of Minnesota is an equal opportunity educator & employer.

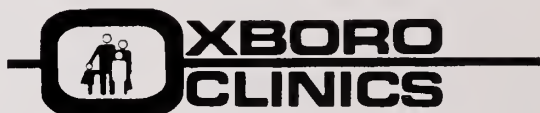
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

UPDATES IN OPHTHALMOLOGY AND OTOLARYNGOLOGY FOR PHYSICIANS

Saturday, March 4, 1995

7:30 AM — 2:00 PM

Minnesota World Trade Conference Center
400 Minnesota World Trade Center
St. Paul, Minnesota 55101

SPONSORED BY:

HealthEast  **St. Joseph's Hospital**

**There is no registration fee for this program.
TO REGISTER, PLEASE CALL 221-9849**

PRESENTED BY:

ST. PAUL EYE CLINIC, P.A.

OPHTHALMOLOGY ~ OPHTHALMIC SURGERY

*Otolaryngology & Head
and Neck Surgery, P.A.*



**Blue Cross
Blue Shield
Blue Plus**
of Minnesota

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JANUARY 1995

Jan. 9-13 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Jan. 20-22 **Mid-Minnesota Medical Symposium for Primary Care Physicians** St. Cloud Hospital; Holiday Inn, St. Cloud, MN. CONTACT: Deb Hardy, Medical Staff Office, 1406 Sixth Avenue North, St. Cloud, MN 56303; 612/255-5626.

Jan. 30-Feb. 3 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

FEBRUARY 1995

Feb. 1-8 **Update in Clinical Neurophysiology** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 3 **1995 Rheumatology Conference-Duluth Clinic** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55802; 218/725-3838.

Feb. 4-8 **Selected Topics in Internal Medicine** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 9-11 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 10 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 15-19 **Pain Management Conference** MeritCare; Big Mountain, Whitefish, MT. CONTACT: Sue Heinze, 720 Fourth Street North, Fargo, ND 58008; 701/234-5737.

Feb. 20-24 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Feb. 24 **Through the Eyes of Others: Is Health Care Culturally Competent?** Hennepin County Medical Center; Earle Brown Continuing Education Center, St. Paul Campus, St. Paul, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078; or Robin Hoppenrath, 612/337-7128.

Feb. 25 **Issues In Pediatrics** MeritCare Children's Hospital; Holiday Inn, Fargo, MN. CONTACT: Sue Heinze, MeritCare Children's Hospital, 720 4th Street North, Fargo, ND 58122; 701/234-5737.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

JANUARY 1995

Jan. 11 **Symposium on Infectious Diseases** Duluth Clinic and Miller-Dwan Medical Center; Miller-Dwan Medical Center, Duluth, MN. CONTACT: Linda Kratt, 502 East Second Street, Duluth, MN 55805; 218/720-1112.

MARCH 1995

Mar. 11 **Infectious Diseases** Group Health Foundation; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Debbie Beadine, 8100 30th Avenue South, Bloomington, MN 55425; 612/883-5341.

Mar. 24 **The Primary Care of HIV 1995** Allina; Holiday Inn International, Bloomington, MN. CONTACT: Don Young, Allina, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

MAY 1995

May 5-6 **Common Infections of Mothers and Infants-Prevention and Management** Children's Health Care, Minneapolis/St. Paul; St. James Hotel, Red Wing, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-5884.

MARCH 1995

Mar. 9 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-10 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 13-17 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Mar. 17 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 24 **Eleventh Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth,

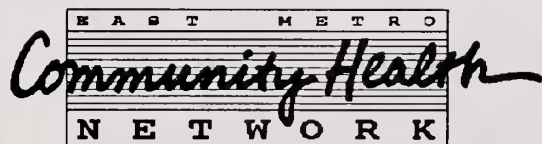
MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Mar. 24-26 **Advances in Clinical Anesthesiology** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 27-31 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Mar. 30-31 **Critical Care 1995** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 31 **John I. Coe Symposium** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078; or Robin Hoppenrath, 612/337-7128.



Nurse Practitioner

The East Metro Community Health Network has full and part-time openings for a Nurse Practitioner in Adult or Family medicine. The ideal candidate will have an interest in working with low-income/minority populations. Must be a graduate of an accredited program and licensed to practice in Minnesota. Attractive hours, salary, benefits. Interested applicants send resume to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

MMA-Accredited CME Sponsors

♣ The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor CME activities for local physicians. ♣ Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating the amount and category of credit for CME activities. ♣ CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." ♣

The MMA Committee on Accreditation and CME has recently granted initial accreditation to Olmsted Medical Group, Rochester, and has reaccredited the following CME sponsors:

- ♣ HealthEast Midway Hospital, St. Paul
- ♣ HealthEast St. Joseph's Hospital, St. Paul
- ♣ Park Nicollet Medical Foundation, Minneapolis
- ♣ St. Joseph's Medical Center, Brainerd
- ♣ VA Medical Center, St. Cloud

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., January 15 for March ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician, multispecialty practice located just south of the Twin Cities

on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

4th Annual Neurology for Primary Care Physicians

- Friday, May 19 — Saturday, May 20, 1995
- Landmark Resort and Conference Center
Egg Harbor, Wisconsin (Door County)

For more information contact:

Marshfield Clinic
Office of Medical Education
1000 North Oak Ave.
Marshfield, WI 54449
1/800-541-2895



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 20 physician multi-specialty Group currently recruiting additional physicians in the following specialties:

- GENERAL SURGERY
- INTERNAL MEDICINE
- OBSTETRICS & GYNECOLOGY
- FAMILY PRACTICE
- PEDIATRICS

First year salary guarantee with production bonus, second year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Timothy A. Hunt, Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

PSYCHIATRIST — The St. Cloud Minnesota Veterans Affairs Medical Center is a dynamic 556-bed facility providing excellent psychiatric, intermediate, and chemical dependency care to veterans.

An exceptional opportunity exists for a physician who possesses leadership skills and is board certified/board eligible in Psychiatry with an interest in addiction therapy to be the Medical Director of a Chemical Dependency Center. We offer competitive salary and benefits combined with a stable 40-hour weekly schedule.

To explore this unique opportunity, call or write:

Pat Barth
Human Resources Management Service
(612) 255-6301, or
Dr. William Jordan
Chief, Psychiatry Service
(612) 255-6368
VA Medical Center
4801 N. 8th Street
St. Cloud, MN 56303
Equal Opportunity Employer

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Family Practice—North St. Paul, Minnesota: Family practice group of four seeks to fill vacancy. Full range of family practice with ob/pediatrics/geriatrics. Stable community clinic since 1946 with excellent growing patient population. Hospital affiliation is St. John's Northeast and HealthEast facilities. Opportunity for one-year salaried position with subsequent buy-in to partnership. Clinic is associated with East Metro Health Organization with multiple insurance contracts. Contact: Marty Dennison, M.D., 2579 East Seventh Avenue, North St. Paul, MN 55109; 612/777-7414. *2-1/95

University of Minnesota School of Dentistry invites applicants through 6/30/95 for part-time non-regular faculty for consultative diagnostic and treatment planning services in specialty clinics. M.D. required, with training and experience in otolaryngology or reconstructive surgery cleft palate patient care. Faculty rank dependent upon experience and training. Send résumé (indicating specialty or area[s] of clinical expertise) to: Dean Richard P. Elzay, University of Minnesota School of Dentistry, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. *2-1/95

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-5237 MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.



South Lake Clinic - Pediatrics West is currently taking applications for 3-5 BC/BE Pediatricians to join the 11 Pediatricians in our dynamic, growing practice. We are looking for Pediatricians who share our commitment to quality, personalized care in a nurturing environment. South Lake Clinic serves a diverse patient base in both inner and outer ring western suburbs of Minneapolis. If you are seeking a challenging and meaningful career, this opportunity may be for you. For further information, contact Dale Dobrin, MD, Medical Director, at (612) 474-5484 or submit your CV to:

South Lake Clinic-Pediatrics West
Attn. Dale Dobrin, MD, Medical Director
17705 Hutchins Drive
Minnetonka, MN 55345

LAKE CITY CLINIC

Family Physicians

Travel & Leisure magazine calls Lake City and Lake Pepin "wild, magical, unspoiled, undiscovered" and "a world apart" (6/94). Why live and work elsewhere when opportunities for family physicians exist in Lake City? Join 4 other FP's and share in a broad range of benefits and generous income.

Please contact:

Frank Thorngren, M.D.
Lake City Clinic PA
303 South Washington Street
Lake City, MN 55041
Phone: (612) 345-3318
Fax: (612) 345-3435



Columbia Park Medical Group

- OB/GYN ● BC/BE Specialists
- Family Practice ● Internal Medicine

OB/GYN:

Three BC Physicians are looking for a fourth to join in their busy practice.

FAMILY PRACTICE: Join Group or do Locum Tenens
Join 25 member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE:

Six member Department has busy hospital and clinic practice.

Columbia Park Medical Group is a physician owned multi-specialty group. The 60 physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered.

Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Tom Behrend
(612) 586-5882

BC/BE Family Practitioner/Obstetrician Wanted: Join an established multispecialty group practice in north-central South Dakota on beautiful Lake Oahe. Competitive salary and benefits package. Send CV or call Bev Simons, Mobridge Medical Clinic, PO Box 520, Mobridge, SD 57601; 605/845-2962. *1-1/95

Too Busy? Let Me Write your peer reviewed papers, poster presentations, book chapters, promotion newsletters, speeches. Call Michael Anthony, 612/673-4445 or 341-0080. *1-1/95

Family Practice/General Surgeon, BC/BE, to join progressive 25-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Hwy. 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. *3-2/95

BC Family Physician to join high-quality, 17-M.D., single-specialty family practice group. Four sites in the Minneapolis northwest metro area. Very reasonable lifestyle with competitive salary and benefits. Contact Jamie Peters, M.D., Northwest Family Physicians, 1495 State Highway 101 North, Plymouth, MN 55447; 612/476-6776. *3-3/95

URGENT CARE OPPORTUNITIES

Group Health, Inc.

Group Health, Inc. is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24 hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, or 1-800-472-4695, or send CV to: **Group Health, Inc.,** Physician Services, Attn: Ann Johnson, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



*Group Health is part of the
HealthPartners family of health plans.*

EO/AA Employer

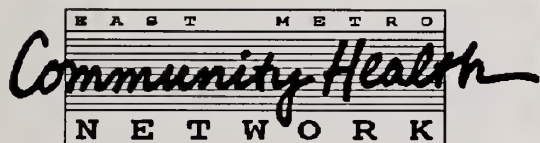


HealthPartners

Mork Clinic, P.A.—Anoka, Minnesota: BC/BE obstetrician/gynecologist needed to join growing physician-owned, primary care, multispecialty, seven-physician clinic. Two well-equipped offices in Anoka and Elk River. Utilization of one hospital. Excellent professional opportunity with ample time to enjoy family life. Contact Curt Keller, M.D., Mork Clinic, P.A., 1833 Second Avenue South, Anoka, MN 55303. *3-3/95

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *3-3/95

Internal Medicine—Carroll, Iowa: Outstanding opportunity for an internal medicine physician in a progressive, safe, and clean community of 10,000 located in west-central Iowa, 90 miles from Des Moines, Iowa, or Omaha, Nebraska. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 square-foot outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, St. Anthony Regional Hospital, 800/382-4197. *6-4/95



**Physician
Family Medicine**

The East Metro Community Health Network is seeking a BC/BE family medicine physician with an interest in community-based health care. The ideal candidate will have an interest in working with low-income/minority populations. Must be licensed to practice in Minnesota. Attractive hours, salary, benefits. No call. Full and part-time positions available. Interested applicants send CV's to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

**RED CEDAR
CLINIC, S.C.**



Beautiful Western Wisconsin community, one hour East of Minneapolis.

Red Cedar Clinic, S.C. is a 19-physician, multi-specialty group currently recruiting additional family practice physicians.

First year guaranteed salary with production bonus. Excellent benefit package.

For additional information, please contact:

Steven J. Lindberg
Administrator
Red Cedar Clinic, S.C.
2211 Stout Road
Menomonie, WI 54751
715/235-9671

**OUR HIGH GROWTH LOCALE
Means Expanding Opportunity**

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; sub-specialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

St. Croix Falls Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detail CV to:

Cathy Kortas
River Valley Medical Center
 208 S. Adams Street
 St. Croix Falls, WI 54024
 (715) 483-3221

Michigan's Upper Peninsula Escanaba

St. Francis Hospital
University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan
Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed
Family Practice Pediatrics
Internal Medicine Neurology
Orthopedic Surgery OB/GYN
Gastroenterology Urology
Noninvasive Cardiology

Send your CV to Gary Luiten, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/862-9012.

JANUARY 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Army Reserve	55
Aspen Medical Group	30
Astra/Merck Group	Cover 3, Cover 4
C.F. Anderson Co., Inc.	41
Central Minnesota Group Health Plan	42
Chisago Health Services	42
Columbia Park Medical Group	62
Comprehensive Medical Care	63
East Metro Community Health Network	58, 63
Fairview Clinic Services	52
Fargo Clinic MeritCare	29
Gillette Children's Hospital	41
HealthPartners	24, 42, 62
Hennepin County Medical Center	24
Lake City Clinic, P.A.	61
Leonard, Street & Deinard	47
Lindquist & Vennum	53
LPL Financial Services	23
Mankato State University	61
Marshfield Clinic	23, 60
Medical Protective Company	32
Minneapolis Otolaryngology	31
Minnesota Physicians Insurance Agency	49
Moonlight Home Health Care	31
Multicare Associates of the Twin Cities	3
North Memorial Medical Center	15
Oxboro Clinics	56
Red Cedar Clinic	63
River Valley Medical Center	64
South Lake Clinic	61
St. Francis, Inc.	64
St. Paul Eye Clinic	56
St. Paul-Ramsey CME	31
University of Minnesota	Cover 2
University of Minnesota, Duluth	56
Veterans Affairs Medical Center	60
Whitesell Medical Locums, Ltd.	29

In order for us to better meet your needs, please complete the following:

_____ Yes, I would like prescribing information on Plendil® (felodipine)

_____ Yes, I would like a paper-based version

_____ Yes, I would like a windows-based electronic version

_____ Yes, I would like some patient starter doses of Plendil®

You may contact a member of our team at the following:

Astra Merck

505 North Highway, 169, Suite 300

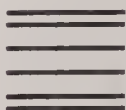
Plymouth, MN 55441

612-593-9450 or 800-578-0690

Physician Name: _____

Physician Address: _____

Physician Phone Number: _____



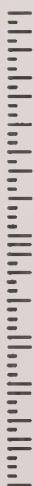
NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 25199 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

Astra Merck
505 North Highway 169, Suite 300
Plymouth, MN 55441-9778



BRIEF SUMMARY

TABLETS

PLENDIL®
(FELDIPINE)

EXTENDED-RELEASE TABLETS

INDICATIONS AND USAGE

PLENDIL® is indicated for the treatment of hypertension. PLENDIL may be used alone or concomitantly with other antihypertensive agents.

CONTRAINDICATIONS

PLENDIL is contraindicated in patients who are hypersensitive to this product.

PRECAUTIONS

General

Hypotension: Felodipine, like other calcium antagonists, may occasionally precipitate significant hypotension and rarely syncope. It may lead to reflex tachycardia which in susceptible individuals may precipitate angina pectoris. (See ADVERSE REACTIONS.)

Heart Failure: Although acute hemodynamic studies in a small number of patients with NYHA Class II or III heart failure treated with felodipine have not demonstrated negative inotropic effects, safety in patients with heart failure has not been established. Caution therefore should be exercised when using PLENDIL in patients with heart failure or compromised ventricular function, particularly in combination with a beta blocker.

Elderly Patients or Patients with Impaired Liver Function: Patients over 65 years of age or patients with impaired liver function may have elevated plasma concentrations of felodipine and may therefore respond to lower doses of PLENDIL. These patients should have their blood pressure monitored closely during dosage adjustment of PLENDIL and should rarely require doses above 10 mg. (See CLINICAL PHARMACOLOGY AND DOSAGE AND ADMINISTRATION sections of complete Prescribing Information.)

Peripheral Edema: Peripheral edema, generally mild and not associated with generalized fluid retention, was the most common adverse event in the clinical trials. The incidence of peripheral edema was both dose- and age-dependent. Frequency of peripheral edema ranged from about 10 percent in patients under 50 years of age taking 5 mg daily to about 30 percent in those over 60 years of age taking 20 mg daily. This adverse effect generally occurs within 2-3 weeks of the initiation of treatment.

Information for Patients

Patients should be instructed to take PLENDIL whole and not to crush or chew the tablets. They should be told that mild gingival hyperplasia (gum swelling) has been reported. Good dental hygiene decreases its incidence and severity.

NDTE: As with many other drugs, certain advice to patients being treated with PLENDIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Beta-Blocking Agents: A pharmacokinetic study of felodipine in conjunction with metoprolol demonstrated no significant effects on the pharmacokinetics of felodipine. The AUC and C_{max} of metoprolol, however, were increased approximately 31 and 38 percent, respectively. In controlled clinical trials, however, beta blockers including metoprolol were concurrently administered with felodipine and were well tolerated.

Cimetidine: In healthy subjects pharmacokinetic studies showed an approximately 50 percent increase in the area under the plasma concentration-time curve (AUC) as well as the C_{max} of felodipine when given concomitantly with cimetidine. It is anticipated that a clinically significant interaction may occur in some hypertensive patients. Therefore, it is recommended that low doses of PLENDIL be used when given concomitantly with cimetidine.

Digoxin: When given concomitantly with felodipine the peak plasma concentration of digoxin was significantly increased. There was, however, no significant change in the AUC of digoxin.

Anticonvulsants: In a pharmacokinetic study, maximum plasma concentrations of felodipine were considerably lower in epileptic patients on long-term anticonvulsant therapy (e.g., phenytoin, carbamazepine, or phenobarbital) than in healthy volunteers. In such patients, the mean area under the felodipine plasma concentration-time curve was also reduced to approximately six percent of that observed in healthy volunteers. Since a clinically significant interaction may be anticipated, alternative antihypertensive therapy should be considered in these patients.

Other Concomitant Therapy: In healthy subjects there were no clinically significant interactions when felodipine was given concomitantly with indomethacin or spironolactone.

Interaction with Food: See CLINICAL PHARMACOLOGY, Pharmacokinetics and Metabolism section of complete Prescribing Information.

Carcinogenesis, Mutagenesis, Impairment of Fertility

In a two-year carcinogenicity study in rats fed felodipine at doses of 7.7, 23.1 or 69.3 mg/kg/day (up to 28 times¹ the maximum recommended human dose on a mg/m² basis), a dose-related increase in the incidence of benign interstitial cell tumors of the testes (Leydig cell tumors) was observed in treated male rats. These tumors were not observed in a similar study in mice at doses up to 138.6 mg/kg/day (28 times¹ the maximum recommended human dose on a mg/m² basis). Felodipine, at the doses employed in the two-year rat study, has been shown to lower testicular testosterone and to produce a corresponding increase in serum luteinizing hormone in rats. The Leydig cell tumor development is possibly secondary to these hormonal effects which have not been observed in man.

In this same rat study a dose-related increase in the incidence of focal squamous cell hyperplasia compared to control was observed in the esophageal groove of male and female rats in all dose groups. No other drug-related esophageal or gastric pathology was observed in the rats or with chronic administration in mice and dogs. The latter

species, like man, has no anatomical structure comparable to the esophageal groove.

Felodipine was not carcinogenic when fed to mice at doses of up to 138.6 mg/kg/day (28 times¹ the maximum recommended human dose on a mg/m² basis) for periods of up to 80 weeks in males and 99 weeks in females.

Felodipine did not display any mutagenic activity *in vitro* in the Ames microbial mutagenicity test or in the mouse lymphoma forward mutation assay. No clastogenic potential was seen *in vivo* in the mouse micronucleus test at oral doses up to 2500 mg/kg (506 times¹ the maximum recommended human dose on a mg/m² basis) or *in vitro* in a human lymphocyte chromosome aberration assay.

A fertility study in which male and female rats were administered doses of 3.8, 9.6 or 26.9 mg/kg/day showed no significant effect of felodipine on reproductive performance.

Pregnancy

Pregnancy Category C

Teratogenic Effects: Studies in pregnant rabbits administered doses of 0.46, 1.2, 2.3 and 4.6 mg/kg/day (from 0.4 to 4 times¹ the maximum recommended human dose on a mg/m² basis) showed digital anomalies consisting of reduction in size and degree of ossification of the terminal phalanges in the fetuses. The frequency and severity of the changes appeared dose-related and were noted even at the lowest dose. These changes have been shown to occur with other members of the dihydropyridine class and are possibly a result of compromised uterine blood flow. Similar fetal anomalies were not observed in rats given felodipine.

In a teratology study in cynomolgus monkeys no reduction in the size of the terminal phalanges was observed but an abnormal position of the distal phalanges was noted in about 40 percent of the fetuses.

Nonteratogenic Effects: A prolongation of parturition with difficult labor and an increased frequency of fetal and early postnatal deaths were observed in rats administered doses of 9.6 mg/kg/day (4 times¹ the maximum human dose on a mg/m² basis) and above.

Significant enlargement of the mammary glands in excess of the normal enlargement for pregnant rabbits was found with doses greater than or equal to 1.2 mg/kg/day (equal to the maximum human dose on a mg/m² basis). This effect occurred only in pregnant rabbits and regressed during lactation. Similar changes in the mammary glands were not observed in rats or monkeys.

There are no adequate and well-controlled studies in pregnant women. If felodipine is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential hazard to the fetus, possible digital anomalies of the infant, and the potential effects of felodipine on labor and delivery, and on the mammary glands of pregnant females.

Nursing Mothers

It is not known whether this drug is secreted in human milk and because of the potential for serious adverse reactions from felodipine in the infant, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

In controlled studies in the United States and overseas approximately 3000 patients were treated with felodipine as either the extended-release or the immediate-release formulation.

The most common clinical adverse experiences reported with PLENDIL® (felodipine) administered as monotherapy in all settings and with all dosage forms of felodipine were peripheral edema and headache. Peripheral edema was generally mild, but it was age- and dose-related and resulted in discontinuation of therapy in about 4 percent of the enrolled patients. Discontinuation of therapy due to any clinical adverse experience occurred in about 9 percent of the patients receiving PLENDIL, principally for peripheral edema, headache, or flushing.

Adverse experiences that occurred with an incidence of 1.5 percent or greater during monotherapy with PLENDIL without regard to causality are compared to placebo in the table below.

Percent of Patients with Adverse Effects in Controlled Trials of PLENDIL as Monotherapy (incidence of discontinuations shown in parentheses)

Adverse Effect	PLENDIL® N = 730	Placebo N = 283
Peripheral Edema	22.3 (4.2)	3.5
Headache	18.6 (2.1)	10.6
Flushing	6.4 (1.0)	1.1
Dizziness	5.8 (0.8)	3.2
Upper Respiratory		
Infection	5.5 (0.1)	1.1
Asthma	4.7 (0.1)	2.8
Cough	2.9 (0.0)	0.4
Paresthesia	2.5 (0.1)	1.8
Dyspepsia	2.3 (0.0)	1.4
Chest Pain	2.1 (0.1)	1.4
Nausea	1.9 (0.8)	1.1
Muscle Cramps	1.9 (0.0)	1.1
Palpitation	1.8 (0.5)	2.5
Abdominal Pain	1.8 (0.3)	1.1
Constipation	1.6 (0.1)	1.1
Diarrhea	1.6 (0.1)	1.1
Pharyngitis	1.6 (0.0)	0.4
Rhinitis	1.6 (0.0)	0.0
Back Pain	1.6 (0.0)	1.1
Rash	1.5 (0.1)	1.1

In the two dose response studies using PLENDIL as monotherapy, the following table describes the incidence (percent) of adverse expe-

riences that were dose-related. The incidence of discontinuations due to these adverse experiences are shown in parentheses.

Adverse Effect	Placebo N = 121	2.5 mg N = 71	5.0 mg N = 72	10.0 mg N = 123	20 mg N = 50
Peripheral Edema	2.5 (1.6)	1.4 (0.0)	13.9 (2.8)	19.5 (2.4)	36.0 (10.0)
Palpitation	0.8 (0.8)	1.4 (0.0)	0.0 (0.0)	2.4 (0.8)	12.0 (8.0)
Headache	12.4 (0.0)	11.3 (1.4)	11.1 (0.0)	18.7 (4.1)	28.0 (18.0)
Flushing	0.0 (0.0)	4.2 (0.0)	2.8 (0.0)	8.1 (0.8)	20.0 (8.0)

In addition, adverse experiences that occurred in D.5 up to 1.5 percent of patients who received PLENDIL® (felodipine) in all controlled clinical studies (listed in order of decreasing severity within each category) and serious adverse events that occurred at a lower rate and were found during marketing experience (those lower rate events are in italics) were: *Body as a Whole:* Facial edema, warm sensation; *Cardiovascular:* Tachycardia, myocardial infarction, hypotension, syncope, angina pectoris, arrhythmia; *Digestive:* Vomiting, dry mouth, flatulence; *Hematologic:* Anemia; *Musculoskeletal:* Arthralgia, arm pain, knee pain, leg pain, foot pain, hip pain, myalgia; *Nervous/Psychiatric:* Depression, anxiety disorders, insomnia, irritability, nervousness, somnolence; *Respiratory:* Bronchitis, influenza, sinusitis, dyspnea, epistaxis, respiratory infection, sneezing; *Skin:* Contusion, erythema, urticaria; *Urogenital:* Decreased libido, impotence, urinary frequency, urinary urgency, dysuria.

Felodipine, as an immediate release formulation, has also been studied as monotherapy in 680 patients with hypertension in U.S. and overseas controlled clinical studies. Other adverse experiences not listed above and with an incidence of 0.5 percent or greater include: *Body as a Whole:* Fatigue; *Digestive:* Gastrointestinal pain; *Musculoskeletal:* Arthritis, local weakness, neck pain, shoulder pain, ankle pain; *Nervous/Psychiatric:* Tremor; *Respiratory:* Rhinitis; *Skin:* Hyperhidrosis, pruritus; *Special Senses:* Blurred vision, tinnitus; *Urogenital:* Nocturia.

Gingival Hyperplasia: Gingival hyperplasia, usually mild, occurred in <0.5 percent of patients in controlled studies. This condition may be avoided or may regress with improved dental hygiene. (See PRECAUTIONS, Information for Patients.)

Clinical Laboratory Test Findings

Serum Electrolytes: No significant effects on serum electrolytes were observed during short- and long-term therapy.

Serum Glucose: No significant effects on fasting serum glucose were observed in patients treated with PLENDIL in the U.S. controlled study.

Liver Enzymes: One of two episodes of elevated serum transaminases decreased once drug was discontinued in clinical studies; no follow-up was available for the other patient.

OVERDOSSAGE

Dral doses of 240 mg/kg and 264 mg/kg in male and female mice, respectively and 2390 mg/kg and 2250 mg/kg in male and female rats, respectively, caused significant lethality.

In a suicide attempt, one patient took 150 mg felodipine together with 15 tablets each of atenolol and spironolactone and 20 tablets of nitrazepam. The patient's blood pressure and heart rate were normal on admission to hospital; he subsequently recovered without significant sequelae.

Overdosage might be expected to cause excessive peripheral vasodilation with marked hypotension and possibly bradycardia.

If severe hypotension occurs, symptomatic treatment should be instituted. The patient should be placed supine with the legs elevated. The administration of intravenous fluids may be useful to treat hypotension due to overdosage with calcium antagonists. In case of accompanying bradycardia, atropine (0.5-1 mg) should be administered intravenously. Sympathomimetic drugs may also be given if the physician feels they are warranted.

It has not been established whether felodipine can be removed from the circulation by hemodialysis.

DOSSAGE AND ADMINISTRATION

The recommended initial dose is 5 mg once a day. Therapy should be adjusted individually according to patient response, generally at intervals of not less than two weeks. The usual dosage range is 5-10 mg once daily. The maximum recommended daily dose is 20 mg once a day. That dose in clinical trials showed an increased blood pressure response but a large increase in the rate of peripheral edema and other vasodilatory adverse events (see ADVERSE REACTIONS). Modification of the recommended dosage is usually not required in patients with renal impairment.

PLENDIL should be swallowed whole and not crushed or chewed.

Use in the Elderly or Patients with Impaired Liver Function:

Patients over 65 years of age or patients with impaired liver function, because they may develop higher plasma concentrations of felodipine, should have their blood pressure monitored closely during dosage adjustment (see PRECAUTIONS). In general, doses above 10 mg should not be considered in these patients.



For more detailed information, consult your Astra/Merck Specialist or see complete Prescribing Information.
Astra/Merck Group of Merck & Co., Inc.
725 Chesterbrook Boulevard, Wayne, PA 19087

PLENDIL is a product of Astra/Merck Research
Copyright ©1994 by Astra/Merck Group of Merck & Co., Inc.
All rights reserved
7650203

Just how powerful is it?



PLENDIL. A highly effective calcium channel blocker for blood pressure control.

PLENDIL provides a gradual onset of action for continuous 24-hour blood pressure control in many patients.

PLENDIL is suited to a broad range of your hypertensive patients – including many with concomitant disorders, such as: hypercholesterolemia, diabetes, impaired renal function, COPD, or asthma.

Generally well tolerated at usual dosages.*

And, the vast majority of patients on PLENDIL receive prescriptions for 5 mg, once daily.[†]



Plendil[®]

(felodipine) Tablets,
5 mg, 10 mg

Because you consider the whole patient.

* Peripheral edema is the most common unwanted effect and is generally mild and age- and dose-related.

[†] 1993 IMS NPA Prescription Data.

Please see brief summary of Prescribing Information on next page.

Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

12977-41107
Univ. of Pittsburgh
Folk Library of the Health
Profession
Pittsburgh, PA 15261-0001

When Medicine Can't Cure

In The Monitor:

MMA Takes Quality &

Coverage Act to the Legislature

F E B R U A R Y 1 9 9 5



Pierre duCharme
Perham



Rick Sall
Duluth



Rich Westlund
Hutchinson



Don Anderson
St. Cloud



Dave Westlund
Hutchinson



Joe Steck
Mankato



Scott Weiloge
Mankato



Jim Erickson
Rochester

*Quality...Service...
Convenience...
from people you
can trust.*

Minnesota Physicians Insurance Agency is a statewide network of counselors uniquely dedicated to personally managing risk for physicians, their families, their clinic, and their employees. You can count on us to deliver the highest quality insurance products at the best possible price, negotiated specifically for you. We combine expertise with a level of service and convenience health care professionals like you have the right to expect.

Call us at **612/623-2860** or toll free **800/298-MMBR**, and we'll send you an overview of available products.

**MINNESOTA PHYSICIANS
INSURANCE AGENCY**

A MMBR Company

*Owned by the members
of MMA and HCMS.*



Angelo Erickson
Hastings



Debro Newmon
Edina



Dick Mussell
Anoka



Mike Prozich, D.D.S.
Plymouth



Brion Mikkelsen
Minneapolis



Wil Heupel
Minneapolis



Mark Bryant
Wayzata



Bob Anderson
Hopkins

FEB 14 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Illustration by Lee Christiansen.

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 24 AUTHOR INSTRUCTIONS
- 53 NEWS CLIPS
- 57 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

- 6 THE LIFE OF A BIOETHICIST** Margaret Rog
From formulating policy to supporting grieving families, Karen Grandstrand Gervais, director of the Minnesota Center for Health Care Ethics, is doing her share to address tough health care issues.

PERSPECTIVES

- 8 FINAL BLOOM** Roger M. Cass, M.D.
At age 91, this physician's mother still had a sound mind and every bit of her Irish wit, but she wasn't willing to live the rest of her life in pain.

FEATURE STORY

- 10 BEARING THE BAD NEWS** Katie M. Colón
Delivering a bad prognosis to patient and family is possibly a doctor's most difficult task; some experienced physicians offer advice.

EDITORIAL

- 15 END-OF-LIFE CARE IN MINNESOTA** Steven Miles, M.D., Eileen Weber, R.N.
Minnesota has made progress in treating and comforting dying patients, but much can still be done.

SPECIAL REPORT

- 18 OVERCOMING PHYSICIAN BARRIERS TO HOSPICE CARE** Wayne H. Thalhuber, M.D.
Hospice offers quality, cost-effective care, but resistance continues.

CLINICAL AND HEALTH AFFAIRS

- 25 CANCER PAIN MANAGEMENT IN THE HOSPICE SETTING** .. John C. Manion, M.D.

MEDICINE LAW & POLICY

- 29 THE MEDICAL FUTILITY DEBATE CONTINUES** Margo S. Struthers, J.D., and Brad C. Olson, J.D.
- 43 LESSONS FROM THE BUTCHER CASE** Barbara J. Blumer, J.D.

BOOK REVIEW

- 48 DEATH, SCIENCE, AND GOD: A REVIEW OF THREE BOOKS** Charles R. Meyer, M.D.
Will scientific understanding allow us to master our destiny?

33 *The* Monitor

HIGHLIGHTS MMA takes Quality & Coverage Act to the Legislature
• Summary of bill • Viewpoint—what role should government play in health care? • Marshfield Clinic loses antitrust lawsuit

**IN 1943, WE DISCOVERED
AN INTERESTING TREND:
MEN HAVING BABIES.**

Back before there were computers, hospital claim forms had to be checked by hand. So it took a keen pair of eyes to notice billing charges for male maternity services among the stacks of forms. As it turns out, it was a simple paperwork error that was easily corrected. Fifty years later, we're still committed to making health care as efficient as possible. Our electronic claims system now links virtually every provider in Minnesota and over 140 different health plans nationwide. Last year, this paperless system transmitted more than 13 million claims electronically. Not only are the cost savings enormous, it can actually impact the quality of care you receive. One hospital found its nurses spent 22 percent less time on paperwork and doubled the time spent with patients. This is just one of the many ways Blue Cross and Blue Shield of Minnesota is making real-life improvements in how health care is delivered. For our free guide to better health, call 1-800-922-3822, ext. 20 or 612-946-7400, ext. 20.





**BlueCross BlueShield
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association
Editor-in-Chief
Charles R. Meyer, M.D.
Managing Editor
Meredith McNab
Associate Editor
Susan Rodsjo
Publications Assistant
Kristi Belcamino

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.
Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Frank A. Bures, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.
Secretary
Thomas B. Dunkel, M.D.
Treasurer
Erick Reeber, M.D.
Speaker of the House
Barbara P. Yawn, M.D.
Vice Speaker of the House
Anthony C. Jaspers, M.D.
Past President
C. Randall Nelms Jr., M.D.
Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Ophelia Balcos

Board of Trustees

N.W. District
Charles S. Winjum, M.D.
N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.
N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.
West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.
East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.
S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.
S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.
Resident Member
Scott Stafford, M.D.
Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.
AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair
AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.
Director of Legal Affairs
Mary E. Prentnieks, J.D.
Director of Legislation and Public Policy
David Renner
Director of Communications
Mark S. Vukelich

When Medicine Can't Cure

Charles R. Meyer, M.D.

Scene: Amphitheater at the University of Chicago School of Medicine, 1972. A pale, apprehensive patient in hospital gown and wheelchair is being asked questions by a thin, female physician in a white coat who speaks with a thick Swiss accent. She guides the patient through a narrative of the discovery of his cancer, the revelation of its incurability, and his feelings about his terminal condition. As the interview concludes, the stages of denial and isolation, anger, bargaining, depression, and acceptance described in the doctor's book are memorialized in the patient's responses.

Twenty-five years ago Elisabeth Kübler-Ross, M.D., published "On Death and Dying" and changed the way we view death. Her analysis of the psychological reaction to confronting death eventually catalyzed the use of hospice and living wills and led to the publication of hundreds of books and articles about medicine dealing with death. But we are still in the first grade in our learning about death. Doctors, the health care system, and society need tutoring about treating patients humanely at the end of life; indeed, we may not have progressed beyond the denial stage. In the hope of moving us ahead a few stages, this issue of *Minnesota Medicine* wrestles with end-of-life problems for physicians, "the system," and American society.

Medicine has improved its treatment of terminally ill patients. Hospice, living wills, DNR/DNI orders, and supportive care are medical lexicon entries new in the last 20 years. In the following pages, Wayne Thalhuber, M.D., describes the current status of hospice; John Manion, M.D., outlines pain control measures for hospice patients; and Steve Miles, M.D., and Eileen Weber discuss the



"For doctors and the medical system, death is a failure of our science; for society, it is a breach of the promise of our science."

progress made by Minnesota's health care system in helping people to die. But these authors also identify deficiencies. Physicians underutilize hospice and underprescribe pain medication. The system has created economic and logistical barriers to using hospice. And our laws offer conflicting messages related to end-of-life medical decision making.

Society is, at best, ambivalent about end-of-life issues. As detailed in this month's Medicine Law & Policy articles, our medical and legal systems struggle to clarify and codify the concepts of futile medical treatment and the right to die. Oregon voters fueled the debate this fall when they passed an initiative legalizing physician-assisted suicide for terminally ill patients. For our patients, impending death often signifies a loss of perceived control over their lives. Paradoxically, suicide, M.D.-assist-

ed or not, may be the ultimate attempt at control.

Physicians share this ambivalence toward the end of life. As noted in our feature story by Katie Colon, we resist crossing that threshold to "supportive care" and hesitate communicating to the patient that the goal is no longer to cure.

Ambivalence toward the terminal patient by the health care system, society, and physicians is rooted in the human, and perhaps peculiarly American, reluctance to view death as part of life. For doctors and the medical system, death is a failure of our science; for society, it is a breach of the promise of our science. In "The Plague," Albert Camus portrays a doctor flailing in a losing battle against the plague. Like Sisyphus condemned to an eternal futile exercise, the doctor vows to continue the fight. Unlike Camus' physician, we need to accept the inevitability of aging and death and help our patients do the same. For our dying patients, we need to move from medically trained curer to informed comforter. When we have "bad news," we need to tell it straight, tell it slow, and tell it soft. As Sherwin Nuland states in his recent book, "The Way We Die," we need to redefine hope: "The greatest dignity to be found in death is the dignity of the life that preceded it. This is a form of hope we can all achieve, and it is the most abiding of all. Hope resides in the meaning of what our lives have been." We need to pass that on to our patients and live it ourselves.

It all comes down to acceptance—the fifth stage—the acceptance I saw 23 years ago in that medical school amphitheater. Knowing when to stop fighting and provide comfort, care, companionship, and love in the last hours.

MM

THE LIFE of a BIOETHICIST

*From formulating policy to
supporting grieving families,
Karen Grandstrand Gervais,
director of the Minnesota
Center for Health Care Ethics,
is doing her share to address
tough health care issues.*

Karen Grandstrand Gervais was with the Butcher family when their son Jamie died. Gervais had been an advocate for the Butchers as they fought for the right to remove their son's feeding tube, 17 years after a car accident left him in a permanent vegetative state. She wrote editorials in support of the Butchers' decision to let their son die. She trained staff at the nursing home where Jamie was a patient. She has been assisting in revisions to the wording of the Vulnerable Adult Act for lawmakers at the state Capitol. And, says Jamie's mother, Pattie, Gervais "handled all the details" immediately after Jamie's death.

That Gervais would be involved on so many levels of a tragedy like the Butchers' is not surprising. This, she says, is the life of a bioethicist: from helping formulate policy to supporting a grieving family, all in a day's work. It's a job for which she's well prepared.

Gervais is director of the Minnesota Center for Health Care Ethics, an 8-month-old organization whose goal is to promote ethically informed decision making on issues related to health care. The nonsectarian center is a collaborative effort between the College of St. Catherine, the Sisters of St. Joseph of Carondelet, Fairview Riverside Medical Center, and HealthEast. This consortium, citing shared interests in values, ethics, and justice, created the center last June and hired Gervais to get it off the ground.

Gervais, who earned a B.A. in religion from Oberlin College and a Ph.D. in philosophy from the University of Minnesota, developed as a bioethicist during her 14 years as a philosophy professor at Illinois Wesleyan University. There, she created a program in bioethics with an emphasis on death and dying and in 1987 published a book, "Redefining Death."

Gervais' interest in end-of-life issues was provoked at least in part by the aging of her own parents. "I really began my work in medical ethics hoping to solve a personal problem," she says. "I thought that my philosophical skills might be helpful in addressing the difficult questions the issues of death and dying raise in our lives."

Gervais returned to her home state of Minnesota in 1989 at the invitation of Arthur Caplan, then director of the Center for Biomedical Ethics at the University of Minnesota, where she became an associate. She was thrilled at the prospect of "coming home" to Minneapolis with her two daughters, Heidi, now 16, and Kerry, 12. At the university, she worked on a variety of bioethics projects, including neural and fetal tissue transplantation, RU-486,

BY MARGARET ROG



"There's a substantial legacy and a very active community of bioethicists here in the Twin Cities."

—KAREN GRANDSTRAND GERVAIS, Ph.D.

and adoption ethics, and is planning a third for next fall. "Diversity Summit I" will bring together physicians, advocates, and representatives from the Hmong, Russian Jewish, and Native American populations to discuss end-of-life decision making in the context of their respective cultures and faith traditions. The Diversity Summit will be an annual event and one of the center's major efforts, focusing each year on a central area of health care and the needs of diverse people in the health care setting.

Center staff also have begun work on "The Concept of Medical Futility in Institutional Policies," a project funded by the Medica Foundation that will seek to generate a consensus

and genetic screening. Three years later, Gervais was named coordinator of the Minnesota Network for Institutional Ethics Committees, where she provided education and training to ethics committees in health care facilities throughout the state. She left the network in June to direct the Minnesota Center for Health Care Ethics, a job it seems she'd been preparing for all along. "[Directing the center] permits me to exercise everything in my past by way of training—my background in philosophy and religion, my life as an educator, my interest in law and policy, my skills in networking, and my concern for the quality of people's health care experiences," Gervais says.

The center's staff of four, together with its board of directors, has formulated a mission that focuses on generating and communicating ethical guidelines for health care decision making—with particular emphasis on diverse cultures and faith traditions; emerging technologies and treatments; end-of-life issues; rehabilitation; and health care reform and the evolving physician-patient relationship.

In its short life, the center has already co-sponsored two conferences, on rehabilitation ethics

policy or policies regarding medically futile interventions. More than 30 Minnesota health care institutions will be invited to participate in this project.

There's more. Gervais recently concluded a six-session ethics education series for HealthEast's long-term care facilities, and she has made presentations to diverse groups of professionals on issues ranging from anencephaly to ethics in managed care. She has convened a 10-member task force to develop guidelines for ethical treatment of patients in a permanent vegetative state and their families. The Minnesota center will work to develop guidelines for informed consent regarding living organ donation and to forge constructive ties with managed care organizations in order to develop the new ethic required for decision making under managed care. And then there are the mundane tasks of choosing letterhead, writing letters, filling out grant applications, and connecting with other bioethics professionals—all part of the grand job of building an organization.

"The center's supporting institutions provide it

GERVAIS continued on page 50

Final bloom

— BY ROGER M. CASS, M.D.



She was coming up on her 92nd birthday. ♣ After two lens implants, her eyesight was good and her hearing was, well, selective. She had had a few Stokes-Adams attacks, ♣ a bit of angina, and mild hypertension treated with diltiazem, ♣ but her mind and her Irish wit, every bit of it, were all there.

She had told me when I was a boy, “When people get old they ought to give them a pill.” This went right by me, as did her casual remark 50 years later that she was never going to Hebron Hall, the skilled nursing home in her retirement community.

After 53 years of marriage, she had laid to rest an irritable, demented lover, and at the age of 84 had begun a new life alone, perhaps the best part of her life, as the family matriarch. In her final glorious bloom, she became a delightful and gracious hostess, holding forth from her small apartment, loving and mothering all comers.

She had rented a two-bedroom apartment on the sixth floor of a retirement complex overlooking the treetops of a mature oak wood lot, and she had set up her oil painting studio in the extra bedroom. Although she had trained in oil painting at the Chicago Art Institute, she had lost some of her figure drawing skills while she worked to raise a family during the Depression. But her landscapes were exquisite, and soon there appeared beautiful oils of green oak trees in summertime and snowy branches in winter.

But the clock continued to spin. She had more frequent dizzy spells and periods of overwhelming fatigue when she couldn't pull herself out of bed. Soon, she knew, would come the stroke.

But the coup de grâce was different. While bending over to make the bed, she felt as though her back had broken. The young doctor said very little, only that it was "very bad arthritis." That was it. But she could not stand to live the rest of her life in such pain. In control to her final moment, she finished her last painting, straightened the apartment to perfection, put on her best robe, and sat down, for the last time, in her recliner.

I was working in the office when the long-distance call came. She was found in her chair unresponsive, with fixed dilated pupils, hypotensive, in idioventricular rhythm. Did I want her intubated? No. Resuscitated? No.

Late that night after a long flight, I walked into her darkened hospital room. She was on her

side, breathing softly. Her eyes were closed. She looked quiet, peaceful. I stroked her white hair. There was no response.

Later during that night the phone woke me. The nurse said, "Your mother's respiration stopped at 4:06 a.m."

We found her note the next day. She told how much she loved us all and how the young doctor had told her how very bad her back was.

This marvelous, loving woman with a mind still so bright was gone from our lives forever. Why did she do this to us, when she was still so alive, so vigorous? We still had so much more to talk about! Who would I talk to? Where was I when her back hurt so badly and she needed me? Why didn't she tell me about it? I would have told her that it would get better. But I was a thousand miles away.

Sammy, the undertaker and our family friend, came later. "It's about the death certificate," he said. "I guess they never did any blood tests, so they really don't know the cause of death. I think it would be better if the death certificate said 'heart attack.' I'm going to ask the doctor to change it."

"Yes," I said. "I guess that's what it was, sort of a heart attack."



Illustration by David Rickert.

Roger Cass is from the University of Rochester in Rochester, New York. Reprinted with permission from Cass RM. A pill for old people. Ann Intern Med 1994; 121:717. © 1994 American College of Physicians.

For four days the pediatrician had been unable to bring himself to give the family the news—news he was sure would devastate them. Their once healthy child was brain dead. How would they be able to handle such an overwhelming tragedy? Not sure he could ever tell them himself, the doctor finally called upon consulting neurolo-

gist Ron Cranford,

Bearing the Bad News

M.D., to confirm the diagnosis and talk to the parents. As anticipated, they were devastated. But they also wondered in dismay why they had not been

told earlier; why had the doctor allowed them to hold onto false hope for so long?

Whether a physician is informing a patient he has incur-

able, advanced cancer, telling family members that a loved one is brain dead, or breaking the news to parents that their baby has a severely disabling condition, delivering bad news is perhaps one of the most difficult tasks doctors ever face. How that news is delivered can have a

significant and lasting effect on the relationship between the physician, patient, and the patient's family. *Minnesota Medicine* interviewed several physicians and other health professionals to explore the underlying issues that make this a difficult process for many physicians and to determine methods for effectively communicating such information to patients and their families.

Shifting from Paternalistic to Patient-Centered Care

As recently as 20 years ago, the relationship between physician and patient was still largely paternalistic. Patients and their families did not actively participate in health care decisions and rarely, if ever, questioned whether the doctor knew best. In cases of terminal illness, such as

cancer, the majority of doctors in the 1950s and '60s didn't even tell their patients they had the disease, explains Cranford, neurologist and medical ethicist at Hennepin County Medical Center. Exercising "therapeutic privilege," a doctor might have withheld a poor prognosis from a patient based on the belief that the patient might become overwhelmed, depressed, or even suicidal.

By Katie M. Colón



ILLUSTRATIONS BY LEE CHRISTIANSEN

There existed a certain "conspiracy of silence" between the doctor, nurses, and the patient's family members, Cranford says. "Once they knew the patient had cancer, nobody would talk to anybody about it again. The family didn't know what to do and did not feel free to discuss their feelings." There was a belief that patients should always be offered hope, even false hope, because they wouldn't be able to handle the bad news.

During the last decade or two, however, there has been a gradual shift toward a more patient-centered relationship. Gone is the Marcus Welby era, when the doctors were omniscient in the eyes of their patients, says Edward R. Creagan, M.D., American Cancer Society

"It is always going to be difficult to tell someone that their chances are slim."

—JEAN HARRIS, M.D.

professor of clinical oncology at the Mayo Clinic. Studies and surveys have shown that most of today's patients and their families want open and honest communication with their doctors. And they want the tenor of that communication to include sensitivity to their emotional needs.

"Most patients in the '90s are well informed and very well versed in medical topics," Creagan says. "Most of them will not tolerate a demeaning, authoritative, dictatorial relationship with their physician and will seek out someone they can have a partnership with in the decision-making process. Just as equally as today's patients are looking for advanced medical technology, they are seeking open, honest, and understandable communication with their doctors."

Building a Trusting Relationship

The best way to build a trusting relationship with the patient and family is for the physician to be up-front about the diagnosis and prognosis, not creating an illusion of hope for cure or recovery when there isn't any, Cranford says. While honest communication can be uncomfortable for the physician, it is best for the family

to have a realistic understanding of the situation, he says.

"Families really pick up on the fact that a doctor is hemming and hawing," he explains. "If they find out the truth elsewhere, their trust will be broken and they won't know whether to believe [the physician] in the future."

The belief that patients and families will not be able to handle difficult or even catastrophic news is largely a misconception, Cranford says. "There is a small percentage of families who can't cope and will deny what you're saying. But in 95 percent of the cases that isn't true."

Cranford acknowledges that an overriding fear of liability in today's medical climate might also prompt some clinicians to say less, believing that less information means less liability. Evidence indicates, however, that most malpractice law suits have more to do with whether the patient likes the physician personally than with the physician's medical practice, he says.

"If a doctor does make a mistake, the best chance of avoiding litigation is to go to the family and admit it honestly," says Cranford. "A good physician-patient relationship is very important to limiting liability."

As part of its Project DECIDE (Discussion of Evolving Choices In Dying and Ethics), the Medica Foundation last year conducted a series of roundtable discussions with groups of terminally ill patients, family members, and health care providers. The discussions revealed that one of the key dynamics of

the physician-patient relationship is that, in the eyes of patients and families, doctors "wield overwhelming influence." They are the people most trusted to give accurate information. Patient participants made it clear that they always turn to their physicians to validate whatever information they receive about their condition, regardless of the source, says Linda Davis, a consultant to Project DECIDE at the time.

Although studies show that more and more Americans want to be in charge of making their own end-of-life decisions, it is apparent that they still highly regard their physicians as counselors, trusting their doctors to pro-



vide the information they need to make those decisions, she says. How a doctor first talks to a patient about a terminal diagnosis or other disabling condition can either solidify or render fragile that relationship of trust.

Providing Information and Compassion

Almost everyone who has ever been on the receiving end of bad news remembers the details of when, where, and how they were told, says Davis. "It sets the stage for the whole future relationship between the patient and physician."

The doctor's demeanor while presenting bad news often has as great an impact on patients and families as the news itself, the roundtable results indicate. Participants in the discussions emphasized that in addition to providing honest, understandable information, it is important for physicians to consider the emotional needs of both the patient and family members. They expressed a need for empathy and time to absorb the initial information with the doctor still present in the room.

"The physicians could have shown a little more concern for the family," said one family member. "Maybe they could have just touched you, put their arm around you and said, 'I'm sorry your husband is going to die. There is nothing we can do.' But they shouldn't just come in and say, 'Your husband is going to die' and then leave."¹

For whatever reasons, some physicians simply don't have a great deal of tact when it comes to delivering bad news, says Creagan. "Part of the problem is that most of us learned from our mentors, many of whom were trained in an era when the doctor's word was omnipotent."

No one wants to be the bearer of bad news, says Peter Blasco, M.D., developmental pediatrician on staff at Gillette Children's Hospital in St. Paul. "There is a normal discomfort that people, including doctors, have with chronic illness, or something disfiguring, or a disorder that carries a negative connotation, especially if it is something that is not curable."

It can be particularly difficult to give bad news to families when the patient is a child. In 1991, Pilot Parents-Minnesota conducted a study of parents who were the recipients of bad news about their newborn baby or young child. While most of them were explicit in saying they wanted direct and honest communication from the doctor, they also indicated that caring and compassion were important to how well they accepted the news. Eighty-one percent of the study participants said they were not physically touched by the person delivering the bad news, which seemed to increase the recipient's sense of isolation, says Lynne Frigaard, administrator of Arc Duluth and former director of Pilot Parents.²

In a 1994 article for Gillette Children's *Pediatric*

How to Break the News

Almost every patient and family remembers the details of how they were given bad news, and the effects of the encounter can be profound. Edward R. Creagan, M.D., offers these tips on "how to break bad news and not devastate the patient:"¹

- Sit down with the patient and family members if at all possible. It shows more care and concern than standing and suggests an unhurried presence.
- Make eye-to-eye contact.
- Choose a private area where there will be no interruptions.
- Make no assumptions about how much the patient already understands about his or her condition and use language that the layperson can understand.
- Avoid detailed conversations if the patient is in pain or groggy.
- Give a general overview of the situation, offering an accurate medical diagnosis, implications for

the patient, and various treatment options.

- Offer a "ball-park" estimate of the length of survival, but with a clear understanding that each patient is an individual and that probabilities apply only to groups of patients. Avoid using firm numbers.
- Don't overwhelm the patient with information all in one visit. Give it in little "sound bites" to allow the patient to better absorb and accept the information.
- Recognize, acknowledge, and validate the patient's feelings.
- Find out and address the specific concerns the patient and family may have.
- Offer "realistic" hope whenever possible.

REFERENCE

1. Creagan ET. How to break bad news and not devastate the patient. *Mayo Clin Proc* 1994;69:1015-7.

Perspectives, Blasco notes that another common pitfall is for the physician to talk too fast when giving bad news and to not pause to allow the patient or family members to ask questions or to digest the information they have just heard. He notes that the tendency to speak too fast is almost universally true of residents and may be "mainly a reflection of anxiety that in some cases is due to eagerness to get the session over."

If at all possible, physicians should take time to prepare what they will say and plan to spend as much time as the family needs to discuss the situation, Blasco advises.

While patients have the right to know their medical diagnosis and the implications, Creagan stresses the importance of giving them information in small doses, rather than overwhelming them with it all in one long discussion. "It is far more compassionate and effective to visit with the patient over a period of time, shedding more light on the problem with each encounter," Creagan wrote in a 1993 *Mayo Clinic Proceedings* article.

"One can sense in a few minutes if families and patients are understanding or shutting down from an overload of information," Creagan says. To continue talking in the latter case is pointless, counterproductive, and can be enormously draining. In the ideal situation, meeting with the patient and family over a few days allows them to better absorb the information and to come up with questions.

"The family needs time to deal with the harsh reality of what they've been told," agrees Nancy Massman, clinical nurse specialist in the oncology department at United Hospital in St. Paul. If it is a new diagnosis, she explains, the patient and family may not have a lot of questions immediately, but with time, they may ask the doctor to repeat information, perhaps more than once.

"I've seen doctors throw up their hands in dismay and say, 'We've gone through this over and over.' [Doctors] need to realize that it may take time for the patient to really absorb all the information," says Massman.

Creagan notes that in the case of an outpatient who is unable to come back after the initial visit (such as when a patient has come from out of town to meet with a specialist) it is important that the clinician determine what support systems are available to the patient to help him or her cope with the news after returning home.

Covering Death and Dying in Medical School

As director of the Mayo Medical School's course on palliative medicine, Creagan believes strongly that some formal didactic training is necessary to help prepare physicians to deal effectively and compassionately with the issues surrounding the care of dying patients and their families, including the initial delivery of bad news. With a special focus on the cancer patient, the Mayo course emphasizes the acceptance of death as a natural

process and focuses not only on medical concerns, but on the integration and consolidation of emotional, psychological, and spiritual issues for the patient and family, as well as the clinician.

"Not talking forthrightly to medical students about how to talk forthrightly with patients does not make any of these encounters easier."

—STEVE MILES, M.D.

There has been a "tremendous grass-roots response" to the course curriculum, says Creagan, noting that he has received numerous requests for reprints to be used in various graduate and postgraduate training programs throughout the country.

"There is a need to reorient educational programs to recognize the importance of providing palliative care," he says, adding that in some cases curing the problem is not a realistic or achievable goal. Families generally react positively when a physician is forthright about the reality of such a situation, he says, especially if the doctor offers the realistic hope that measures can be taken to enhance the patient's quality of life, dignity, and comfort during the progression of the disease.

Current American Medical Association statistics show that only five of the 126 accredited medical schools in the United States require that students take a death and dying course. "Relative to how frequently [delivering bad news] occurs, and relative to its importance, it is a topic that has been neglected in medical education," says Steve Miles, M.D., coordinator of the medical ethics course at the University of Minnesota, which recently incorporated a unit for first-year medical students on the subject. "Not talking forthrightly to medical students about how to talk forthrightly with patients does not make any of these encounters easier," he says.

As physicians and patients become partners in decision making, the goal is not only to better convey the bad news, but to help patients make better decisions about their care, Miles says. "We can't ask patients to do that

if [the physician] is not effectively managing the initial communication."

Jean Harris, M.D., senior associate director of the University of Minnesota Hospital and Clinic, believes that in addition to brief didactic training, teaching at the bedside and allowing students to attend interdisciplinary discussions about a patient's care are of great importance. The presence of the family at such discussions offers the student an excellent opportunity to observe the dynamics between the health care team, patient, and family members, she says.

Addressing One's Own Vulnerability

While doctors know intellectually that death is a normal and inevitable part of the human experience, they are not necessarily prepared to deal with it emotionally, says Harris. In medical school the focus is on curing illness and preserving life. "What is not usually a part of a physician's training is the message that there will be times when they are not successful, and that is OK."

For many physicians, telling patients that their condition is incurable or that a certain treatment has failed is like admitting personal failure or defeat, Harris says. Physicians may experience a sense of guilt that maybe they didn't do everything possible to help the patient. Or a physician may suggest to a patient that another treatment might work, even though the physician knows chances are very small it will. This is probably a reflection of the physician's own discomfort with failure—a reluctance to give up, says Harris. But it may also give the patient and family a false sense of hope.

Often playing into this dynamic is a family that wants to try everything possible to save their loved one. They may be experiencing their own feelings of guilt and anger, wondering, for example, why this has to happen to their child, Harris continues. The best thing the physician can do in that instance is to give an honest assessment of the current situation and offer support, she advises.

Before doctors can communicate effectively and compassionately with patients, they must first deal with their own sense of mortality and the losses in their own lives, says psychologist Harry Ireton, Ph.D., who conducts sessions on how to present bad news for residents on the developmental pediatrics rotation at Gillette Children's Hospital.

While discussing loss, grief, and recovery from the point of view of parents who have learned that their child has a disability, Ireton also explores with the residents their own vulnerability as physicians—how the losses in

their own lives interrelate with those they experience as clinicians.

He tells of one pediatric resident who emotionally stated that she had "lost seven children," speaking of them as if they were her own. "Physicians can get attached to their patients, and when one of [these patients] develops a serious health problem or is dying, they may have to deal with their own grief issues," explains Ireton.

"There is very little room made [in medical training] for physicians to deal with loose ends or fallout from difficult situations," says Ireton. Faculty are often very "medical" and hard for students and residents to talk to regarding the emotional issues of communicating bad news and lending long-term support to the patient and family.

"It is always going to be difficult to tell someone that their chances are slim and to deal with people who are vulnerable and in need of emotional, nurturing support," says Harris. But honesty and support from the physician can go a long way toward helping the family feel they've done their best and to alleviate their sense of guilt about the situation, she says.

When it comes to delivering bad news, physicians need to learn to be "comfortable with being uncomfortable," says Cranford. Spending time with the patient and family, even if it means sitting through periods of silence or letting them cry, is better than walking away, he says. "Sometimes the right thing to do, the best thing to do, is the most uncomfortable thing." MM

Katie Colón is a free-lance writer in Champlin, Minnesota, specializing in health care and disability-related subjects.

REFERENCES

1. The Medica Foundation Project DECIDE. A roundtable report to the community. Minneapolis: The Medica Foundation, 1994.
2. Frigaard LR. Giving and receiving bad news. Best Foot Forward (Minnesota Chapter of the American Academy of Pediatrics) 1991 Winter;1(1).



End-of-Life Care in Minnesota

Minnesota has made progress in treating and comforting dying patients, but much can still be done.

Steven Miles, M.D., and Eileen Weber, R.N.

Forty thousand Minnesotans will die this year. Some deaths will be premature; some will be a timely end to a full life. Some will occasion great sadness; others would have been welcomed earlier in the course of debilitating illness. Some deaths will be preventable; some will be fated. Some will follow "heroic" medical rescue attempts; others will follow less heralded, but equally heroic, personal caregiving. In broadest perspective, each individual death in some way will reflect a facet of the larger, universal experience of human mortality.

Nine of 10 deaths take place in the health care system. Health care is inextricably tied to the timing and manner of death. Dying and the practice of end-of-life health care are shaped by a complex confluence of powerful expectations, faiths, fears, emotions, needs, incentives, taboos, laws, and myths, as well as institutional, familial, and personal histories.

Dying is the most costly episode of care in the health care system. One-tenth of health care resources, \$1.5 billion in Minnesota, is spent on the care of persons in their last year of life. For elderly disabled persons, end-of-life resources largely go to home and nursing home care rather than to misused hospital care. For older persons entering the last year of life in good shape, health care is usually centered on a costly, highly aggressive hospital episode. Four of five deaths occur after a quiet conversation and a private decision to

step back from resuscitation, chemotherapy, dialysis, intensive care, or hospitalization and let life end as it will. Neither judges nor newspapers are present as everyday people, too often surprised by the summons, make the hard decisions that must be made when life is precious, mortal, and thoroughly medicalized.

It is instructive to compare the equally universal experience of "end-of-life care" with "beginning-of-life care." Prenatal, obstetric, and postnatal care are completely integrated. End-of-life care is often a hodgepodge of referrals, consultants, and health care providers who do not communicate well with one another; the provider's role in bereavement is barely discussed. The option to choose a birthing center, hospital, or home birth, and the choice of a primary care doctor, a midwife, or a specialist to manage care are actively presented and avidly discussed. Personal views are carefully attended to in this meaningful personal passage. Choices for the equally value-laden passage at the end of life are often vaguely defined, poorly presented, difficult to pursue, capriciously funded, and ill-matched to diverse personal values. The quality of beginning-of-life care is scrupulously monitored and promoted and is a trigger for public health intervention. Outside of hospices, end-of-life care is subject to idiosyncratic quality management; more than half of patients with cancer pain die undertreated.

Minnesota has made progress:

- We have a good foundation of laws and judicial opinions addressing health care, living wills, and durable powers of attorney for health care. Notwithstanding the intrusion of a county attorney at the prompting of a health facility lawyer in the recent Butcher case (see page 43), Minnesota law has respected discretionary bedside decision making by doctors, patients, and caregivers.

- We have a large number of hospice programs. Hospice use by Minnesota cancer patients is above the national average but could be much higher. We need to enhance awareness and use of hospice by a greater diversity of patients. Hospice provides high-quality end-of-life care, meets the need to maintain personally meaningful control over dying, and does not increase health care costs (see page 18).

- We have a fair system of guardians for incompetent persons. Government offices are responsive but plagued by arbitrary, non-codified, regional diversity in procedures, particularly in the requirement for judicial oversight of decisions to forgo treatment. Minnesota Attorney General Hubert Humphrey's role in the 1994 Voeller case is an underpublicized and worthy model for all jurisdictions in this state.¹ That case established that public guardians do not need to go to court to get approval of decisions to forgo life-sustaining treatment, such as feeding tubes.

- We have vigorous and diverse private-sector initiatives, including

the Minnesota Cancer Pain Initiative (which writes guidelines to improve pain control), the Medica Foundation (which supports education and research to improve end-of-life care), ethics centers at the University of Minnesota and the College of St. Catherine (which provide scholarship on end-of-life issues—see page 6), the Minnesota Network for Institutional Ethics Committees (which is a first-of-its-kind, statewide educational system for hospital and nursing home ethics committees supported by the Minnesota Hospital Association), the Minnesota Hospice Organization (which supports hospice development and innovative clinical guidelines for such treatments as palliative radiation for hospice care), and many others. Even so, end-of-life care in Minnesota must be improved.

- We must provide universal funding, with informed and facilitated patient access, to case-managed, multidisciplinary hospice care. Barriers to hospice referrals, misconceptions about hospice capitation and life expectancy, the confusion over the role and reimbursement of hospice programs in nursing homes, and spotty hospice coverage by some insurers and managed care plans are problems in urgent need of fixing.

- We must effectively address myths in the minds of providers and consumers that lead to inadequate pain control (see page 25).

- We must promote standard quality measures for end-of-life care to improve care and help people find providers who will meet their needs.

- We must resolve conflicting legal messages and clarify jurisdictions pertaining to providers' treatment duties and decision making for catastrophically ill, incompetent persons without family or guardians.

- We must empower advance practice nurses to more independently provide end-of-life care (as midwives do with beginning-of-life care) and prescribe narcotics to meet diverse preferences for end-of-life health care and to promote home-based care.

Physician-Assisted Suicide

Oregon's legalization of physician-assisted suicide looms over Minnesota's discussion of end-of-life care.

The new Oregon law says that, after a two-week waiting period, a physician may prescribe lethal doses of drugs to a terminally ill person. Most Minnesotans are sympathetic to this idea. Fifty-nine percent say that it would be right for a doctor to comply with the wish of a person who is irreversibly ill and in severe pain who asks to have his or her life ended (Harris poll, Medica Foundation, 1994). It is unlikely that legalized assisted suicide will come to Minnesota by legislation any time soon. It could, however, be legalized here through case law if a court finds there is a protected personal liberty to make this decision or if a determined physician starts a campaign—knowing that assisting a terminally ill person to commit suicide is extremely difficult to prosecute and can mobilize substantial public support.

Oregon's initiative to legalize physician-assisted suicide must be understood for what it is. It is not a measure to improve end-of-life care. Physician-assisted suicide is not about end-of-life care—it is a way to escape end-of-life health care (see page 8). The physician-patient relationship

will not be a sound foundation for suicide.² This new law is not a shallow recognition of the obvious fact of human mortality. Rather, it expresses a deep, widespread fear of our system of end-of-life health care, a system that is perceived, and too often experienced, as indifferent, mortality-denying, or inaccessible. This new law is a clarion call to address the issues raised by the contributors to this month's *Minnesota Medicine*. MM

Steven Miles is associate professor of medicine at the Hennepin County Medical Center and a faculty associate at the Center for Biomedical Ethics, University of Minnesota. Eileen Weber is a doctoral student at the University of Minnesota and an emergency nurse at the University of Minnesota Hospital in Minneapolis. The authors are supported by the Medica Foundation to address these issues.

REFERENCES

1. In re Guardianship of Arthur Voeller, No. CO 94-3874, Minn. 2nd Jud. Dist., Appellate Court Case No. CO-94-834.
2. Miles SH. Physicians and their patients' suicides. JAMA 1994;271:1719-1810.

Creative solutions for all your health law problems



Leonard, Street and Deinard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

can help me achieve my investment and income objectives.

Name _____
Address _____
City _____
State _____ Zip _____
Phone _____

Please contact me at my ☐ Home ☐ Office

☐ Please send me information on your products and services.

I currently invest in ☐ Stocks ☐ Bonds ☐ Mutual Funds
☐ CDs ☐ Annuities



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES



BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 25248 MPLS MN

POSTAGE WILL BE PAID BY ADDRESSEE

WEBB FINANCIAL GROUP
6600 France Av S, Ste 370
Edina, MN 55435-9886



WEBB FINANCIAL GROUP

INVESTMENT ADVISORS



LeAnn

Les

Jerry

Webb Financial Group has over 44 years in combined investment experience.

We are recognized as a leader in managing low to moderate risk
NO-LOAD FUND portfolios for individuals and retirement plans.

We primarily work with portfolios of \$200,000 or more.

Our mission is to help our clients achieve their investment and income objectives,
while maintaining a long term safe haven for their assets.

Call a personal investment advisor at
Webb Financial Group for a no-cost, no-obligation consultation.

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

Overcoming Physician Barriers to Hospice Care

Hospice offers quality, cost-effective care, but physician reluctance continues.

By Wayne H. Thalhuber, M.D.

"As humans we are taught to try to fight for every last ounce of life, and as doctors we are trained to help people accomplish that. I think for a lot of doctors still, [hospice] goes against the grain."

This statement from a physician was part of a 1993 focus group conducted by HealthEast Hospice to gauge physician knowledge and acceptance of hospice and palliative care. In my experience as medical director of HealthEast Hospice, I, unfortunately, have found this an accurate assessment of how physicians tend to view hospice care. While our program—and hospice in general—has witnessed tremendous growth over the past few years, the evidence clearly suggests that hospice is still greatly underutilized in today's health care system.

The Problem

Last year, the HealthEast Hospice Physician Advisory Committee conducted a chart review of patients who had died at HealthEast Midway Hospital from September 1991 through August 1992. The results showed that 43 out of 55 patients who may have benefited from hospice care were not referred to hospice. For more than half of those cases, the reasons for not referring to hospice included lack of patient/family interest, imminent death, and lack of physician familiarity with hospice philosophy. No reason was cited in the remaining cases.

Similarly, from January 1991 to July 1992, the HealthEast Tumor Registry recorded 1,559 oncology-related deaths. During this time period, HealthEast Hospice received 449 oncology-related referrals—only about 29 percent of the potential number of referrals.¹

HealthEast Hospice's experience is echoed by other

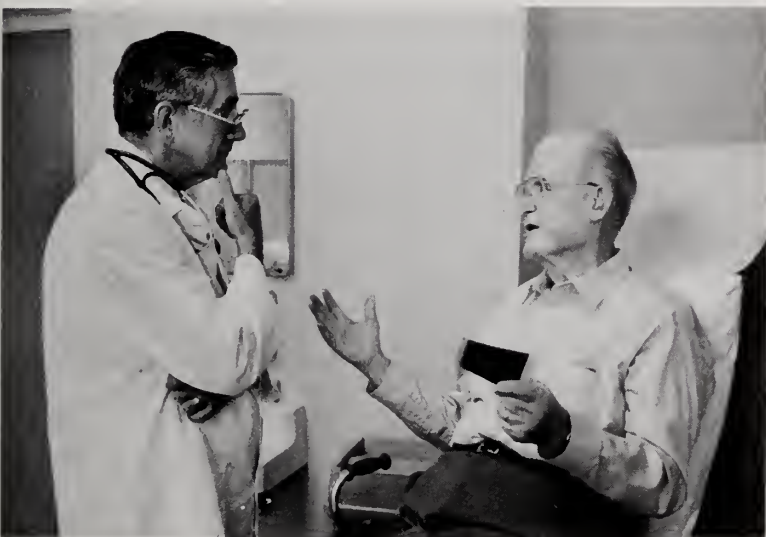


Rev. John Carlsson visits with a patient.

hospice groups both locally and nationally. Bonham et al. report that 71 percent of patients and families surveyed considered hospice once the physician provided information about it; the problem, however, is that at least 25 percent of physicians interviewed said they never discuss hospice with their patients when the opportunity arises.² Not necessarily every patient with a terminal illness is appropriate for hospice—nor will every patient choose hospice—but physicians certainly are not utilizing hospice to its fullest potential.

Today, given persistent cost-containment directives and growing pressure from assisted-suicide proponents, physicians are being forced to evaluate how they care for their terminally ill patients. Hospice is an option that offers quality, comprehensive, cost-effective care and the benefits of an interdisciplinary approach to treating both the patient and family—but it is an option that all too frequently is not offered.

A review of the literature turns up several reported physician barriers to recommending hospice care. If physicians are to provide sound end-of-life palliative medical care that maintains patient choice and dignity, then it is essential that they consider what hospice has to offer and break down the barriers to its use.



Dr. Wayne Thalhuber gives a patient a checkup.

of an impressive array of palliative care services both in Canada and the United States.³

Hospice is working to shed this anti-medicine image. The first textbook of palliative medicine was published in 1993, and palliative care curriculum for medical schools is being developed. Numerous quality research papers have been published regarding pain and symptom management. And the Academy of Hospice Physicians has experienced tremendous growth in U.S. membership and is developing credential exams for palliative care physicians.

Such actions within the hospice community are helping to shape palliative medicine into a specialty that will not only scientifically address the needs of the dying patient, but also will follow the

academic structure required for acceptance by mainstream medicine.

A Grass-roots Movement

Physician barriers to hospice have a historical basis. Hospice began in England in the mid-1960s as a community-based, volunteer movement that grew out of the belief that mainstream medicine was not adequately meeting the medical and social needs of terminally ill patients. This grass-roots hospice movement was considered separate from established health care systems.

The medical community's reaction was predictably defensive. Generally viewing hospice as "anti-physician," medical representatives voiced strong opposition during congressional hearings in the 1980s, arguing that hospice's cost-effectiveness was unproved and that a definition of life expectancy was dubious. With the passage of the Medicare Hospice Benefit in 1982, the medical community's initial reaction was to ignore hospice and hope for a legislative reversal. Although this has not occurred, and despite growing public acceptance of hospice care, some physicians continue to remain cool to the concept.³

Hospice has also been criticized by organized medicine for being holistic and spiritual in nature. Not yet part of medical academia, hospice has been relegated to the "bottom shelf," despite the development

The Physician-Patient Social Contract

According to Ira Bates, a national health care consultant, another barrier to hospice referrals is the unwritten social contract that exists between patients and physicians—a contract that commits physicians to using their extensive training to care for and cure patients' ailments.

Gordon reports that many physicians are hesitant to accept a disease process when the patient is beyond curing. Losing a patient may be equated with lack of physician skill and diminution of physician stature in the eyes of the patient or the family. Some physicians may refuse hospice care for their patients because of their own inability to admit the inevitable.³

Michael Levy, M.D., Ph.D., director of the supportive oncology program at the Fox Chase Cancer Center in Philadelphia, has suggested that some physicians fear that hospice referral signals loss of hope. A physician may not be comfortable acknowledging the futility of further intensive therapeutic interventions. Physicians revert to what they know best, and in some cases, it may

What Is Hospice?

By Dan Holst

Hospice is a special kind of care for dying people and their families that treats the physical, psychological, and spiritual needs of the patient and family. Hospice care emphasizes keeping patients in their homes and concentrates on managing pain, maintaining patient comfort, and supporting quality of life.

Agencies delivering hospice care must be licensed by the Minnesota Department of Health to provide hospice services. Hospices may also choose to become Medicare certified to qualify for third-party reimbursement and may seek JCAHO accreditation.

When all requirements are met, Medicare covers physician services, nursing care, medical appliances and supplies, outpatient drugs for symptom management and pain relief, short-term inpatient care (including respite care), home health aide and homemaker services, physical therapy, occupational and speech/language pathology, medical social services, dietary

services, and spiritual and bereavement counseling.

Minnesota has 73 licensed programs, 37 of which are also Medicare certified. For more information about hospice care, contact:

Minnesota Hospice Organization
Iris Park Place, Suite 36
1885 University Avenue
St. Paul, MN 55104
612/659-0423

The Academy of Hospice Physicians
P.O. Box 114288
Gainesville, FL 32604-2288
904/377-8900

Dan Holst is executive director of the Minnesota Hospice Organization.

seem easier to order more chemotherapy than to address the complex issues involved in stopping aggressive treatments.⁴

However, Levy suggests that instead of telling a patient, "You have six months to live," physicians should say, "I think at this point the burdens of further therapy will outweigh the benefits. I think we should realign our hopes to quality of life. Let's take some time and see what you want to get done before you die and how we can help you do that."⁴

The cost-control impetus behind health system reform is forcing physicians to reassess how end-of-life treatment should be handled. In a system that recognizes limited health care resources, hospice becomes a much more attractive option for end-of-life care. But beyond cost, physicians must recognize the role of hospice within the continuum of care as an integral component of active treatment, not as a drastic end or reduction of treatment.

Loss of Control

While the interdisciplinary approach that hospice takes to treating patients and families is one of its true strengths, it can also be an obstacle to physicians who are reluctant

to share control of patient care with other team members.⁴ This loss of control is exacerbated by changes within the health care marketplace that already complicate the traditional physician-patient relationship.

Within hospice, the interdisciplinary team focuses on the needs of the patient and family, but it is completely reliant on the physician's approval and input in developing the individual hospice care plan. It is the physician—along with the hospice nurses, social workers, home health aides, volunteers, and spiritual/bereavement counselors—who empowers the patient and family to meet the challenges of a terminal illness. Physicians should view the team concept as a wonderful supplement to care, not a detriment. Rather than being burdened with sole responsibility for caring for patients, physicians now have professional, multidisciplinary hospice teams at their disposal to meet the patient's and family's total needs. This team can greatly enhance and extend physicians' care, and it can support the important physician-patient relationship.⁴

According to Ira Byock, M.D., hospice medical director of Partners in Home Care in Missoula, Montana, "Physicians ... can feel part of delivering comprehensive care while only having to do what physicians are trained

and competent to do. Care of the dying stops being a stressor and starts being a source of professional satisfaction."⁴

Patient's Impending Death

When the Medicare Hospice Benefit was created, it included a built-in barrier by requiring physicians to certify that a patient had less than six months to live. That stipulation has been loosened so that a physician need only certify that the patient has less than six months to live if the disease runs its normal course—and there is no penalty if this prognosis is incorrect.

Despite published clinical indicators for poor prognosis in cancer patients, studies have shown that physicians commonly overestimate life expectancy. In many cases, the clinical course of a terminal illness may move along until it becomes too stressful to transfer a patient into a hospice program.⁵

MacDonald notes that the most common reason for not admitting patients to hospice is death before hospice care can be arranged. He lists several factors, including physician hesitancy to discontinue curative treatment, the refusal of American society to accept the dying process, and the difficulty of accurately predicting death.⁶

More research on clinical indicators, as well as increased awareness among physicians, will greatly improve how hospice is used within the continuum of care.

Loss of Income

Another barrier to hospice is the potential loss of financial reimbursement for the physician. Because of its home-care focus and interdisciplinary team involvement, hospice can potentially reduce the number of physician office visits and hospital stays.⁴ However, attending physicians can bill Medicare and other carriers for regular visits related to the hospice care plan. Physicians also may bill Medicare and other carriers for services over and above those provided by the hospice.

Most physicians who use hospice have found that it is well worth its investment in terms of alleviating the stress and demands traditionally associated with caring for dying patients. As Levy notes, the hospice nurse shoulders much of the care. The physician is relieved of calls in the middle of the night and unexpected visits to the emergency room. Hospice interdisciplinary team members are available 24 hours a day to the patient and

family, and they go to great lengths to educate the patient and family regarding medications so that the doses and schedules are correct and side effects are anticipated.⁴

Inadequate Knowledge

As the HealthEast Hospice chart review indicated, one of the primary obstacles to hospice referrals is lack of physician awareness of hospice care. In many ways, hospice is one of the best-kept secrets in health care today—a managed care model for patient-centered interdisciplinary care that actually saves money. Hospice is comprehensive and both supplements and enhances the traditional care provided by home care programs, transitional care units, and nursing homes. As public awareness focuses on end-of-life decision making—especially with the raging debates over physician-assisted suicide—hospice can no longer be kept secret.

It is up to the hospice community to do a better job of working with physicians to manage patients with terminal illnesses. Identifying the physician barriers to hospice and addressing them head-on with physicians is a start. Working closely with physicians to develop and manage the patient care plan is essential to building a strong relationship. And, taking the time to explain the intricacies of hospice—including reimbursement—as well as listening and responding to physician concerns will greatly facilitate physician use of hospice services.

Education is also crucial. The Minnesota Cancer Pain Initiative's goal to broaden physician education in pain management embraces the hospice philosophy. Training of medical students and resident physicians in palliative medicine is absolutely essential to generating acceptance of hospice as part of the continuum of care. The science of palliative medicine, the art of hospice care, as well as methods for dealing with dying patients, should all be included in medical school curriculum. Such efforts are underway at the University of Minnesota, where Kathy Faber-Langendoen, M.D., and Deborah Drew, R.N., are developing a palliative care program.

Solid clinical data on hospice will also lead to greater acceptance by the medical community. For example, while general hospice admission criteria for non-malignant disease have been published,⁷ more specific data are needed to expand hospice's reach to other end-stage disease processes.

Meeting New Challenges

Hospice clearly benefits society and physicians, but wider physician acceptance is necessary before it can be

Refuting Hospice Myths

MYTH: Hospice is a place.

TRUTH: While the word "hospice" refers to an inn for travelers, hospice care for terminally ill patients is a concept of care that is not dependent on any one place. Hospice care refers to the interdisciplinary approach to managing a palliative care treatment program for the terminally ill patient. Most of the time, that care is delivered in the patient's home—whether it's a house, an apartment, or even a nursing home.

MYTH: Hospice only offers emotional support.

TRUTH: While emotional support is a cornerstone of hospice care, it is by no means the only type of support offered by the hospice. Hospice is rooted in palliative medicine and, as such, is concerned foremost with pain control. Each patient is treated by a hospice interdisciplinary team that includes a physician, registered nurses, home health aides, social workers, and counselors. In addition, hospice care may include speech, physical, and occupational therapies—and even chemotherapy or radiation therapy if used as part of a palliative treatment course. Hospice is a professional team approach to treating the whole patient—with the added benefit of support services for family members, including bereavement services for up to one year following the patient's death.

MYTH: Hospice means death.

TRUTH: In a society that celebrates life and youth, hospice has too often been viewed as simply an ending point. But as those who have worked with hospice can attest, the goal of hospice is not death, but life. Hospice care is designed to allow patients with terminal illnesses to live their remaining days, weeks, or months as fully as possible. Dying is a process, but it does not have to be a hopeless, meaningless process. Hospice, with its integrated support services, empowers families to accept death and embrace life.

MYTH: Hospice is only for cancer patients.

TRUTH: While the majority of hospice patients have cancer-related diagnoses (nearly 80 percent, according to the National Hospice Organization), hospice care is appropriate for virtually any terminal diagnosis. The National Hospice Organization is expected to release a report on hospice admission criteria for non-cancer diagnoses later this year.

MYTH: Hospice is alternative care.

TRUTH: Perhaps because it grew out of a grass-roots effort, hospice care is often viewed as being outside the health care continuum. In fact, hospice served more than a quarter million patients and their families last year and is a model for managed care that supports the full continuum of patient care.

utilized to its full potential. Addressing the barriers that currently limit physician acceptance is a good start. In particular, with the impending challenge of physician-assisted suicide, it is essential that the hospice community inform physicians and patients of hospice's quality, family-focused palliative approach to treating dying patients.

MM

Wayne Thalhuber is board certified in internal medicine and is the medical director for HealthEast Hospice.

REFERENCES

1. Novitskie PA. Barriers to hospice referrals [Thesis]. Winona, Minnesota: St. Mary's College, 1993:6-27.
2. Bonham GS, Gocman DS, Burgess L, Fream AM. The hospice decision: multiple determinants. Louisville, Kentucky: University of Louisville Urban Studies Center, 1986.
3. Gordon A. The physician as gatekeeper: access to the hospice Medicare benefit. *Am J Hosp Care* 1989;6(5):44-7.
4. Skelly FJ. Hospice. *Am Med News* 1994 March 28:15-8.
5. Rhymes J. Hospice care in America. *JAMA* 1990;264:369-72.
6. MacDonald D. Non-admissions: the other side of the hospice story. *Am J Hosp Care* 1989 March/April:17-21.
7. Kinzbrunner BM. Non-malignant diseases: criteria for hospice admissions. *Academy of Hospice Physicians Newsletter* 1993 May.

CONTINUING MEDICAL EDUCATION

ST. PAUL - RAMSEY MEDICAL CENTER

Winter/Spring Schedule of Courses

Mark your calendar now for these upcoming conferences:

1995

- March 2-3 Infection Control in Long-Term Care Facilities, Part I, St. Paul
(May 24-25, Part II)
- March 9-10 Family Medicine Today, St. Paul
- March 17 Occupational Medicine Update, St. Paul
- March 24 HIV Primary Care Conference, Bloomington
- March 30-31 Critical Care 1995: Practical Approaches & Case Discussions, St. Paul
- April 6-7 Obstetrics & Gynecology Update, St. Paul
- April 7 ENT Update, St. Paul
- May 24-25 Infection Control in Long-Term Care Facilities, Part II, St. Paul
(March 2-3, Part I)

Information and registration:

Continuing Medical Education, St. Paul - Ramsey Medical Center,
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992, Fax 612/292-4773

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 260 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice for the Region
- Orthopaedics - Detroit Lakes, Bemidji
- General Surgery - Wahpeton
- Psychiatry ■ OB/GYN
- Urgent Care ■ ENT
- Rheumatology ■ Pediatrics - Bemidji
- Internal Medicine -
Detroit Lakes



MeritCare Medical Group
737 Broadway • Fargo, ND 58123

For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010



Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.

3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Cancer Pain Management in the Hospice Setting

John C. Manion, M.D.

ABSTRACT

Pain relief for the cancer patient in the hospice setting is almost always achievable. Cancer pain is caused by tumor growth and by psychosocial and spiritual factors. Opioid drugs are the mainstay of effective treatment. Morphine is the opioid drug of choice. Although tolerance to opioids occurs, tumor growth is the usual reason for escalating opioid dose. Addiction almost never occurs in the cancer patient with pain. These patients don't exhibit drug-seeking behavior or experience the psychic high seen in drug addicts. Nonsteroidal anti-inflammatory drugs and adjuvant analgesics are synergistic with opioids in providing analgesia and allow lower opioid doses and fewer side effects. Ten to 15 percent of hospice patients will require regional anesthesia for pain relief. The hospice team of physicians, nurses, social workers, chaplains, aides, and volunteers is more effective than any single health care provider in achieving optimal pain relief and comfort.

Over the past 20 years, hospice has liberated millions of dying cancer patients from unremitting pain and suffering. Hospice is palliative medical care for the terminally ill patient, as well as care for the caregivers—usually the spouse and the family. The majority of hospice patients have a cancer diagnosis; others have non-cancer terminal diagnoses. Hospice addresses the physical, psychosocial, spiritual, and financial etiologies of patient pain and suffering through a team approach, with help from physicians, nurses, social workers, chaplains, aides, and volunteers. Hospice continues to gain acceptance from the medical community and general population primarily because it works so well. Since the passage of the Hospice Medicare Benefit by Congress in 1982, a generous financial reimbursement for care has allowed a rapid expansion of hospice benefits to the dying patient.

NONOPIOID ANALGESICS

Hospice cancer patients usually have metastatic disease manifested by moderate to severe pain. Pain is primarily palliated by nonopioid and opioid analgesics and adjuvant analgesics. Initially, acetaminophen and nonsteroidal anti-inflammatory drugs will often be satisfactory for mild to moderate pain relief. Nonsteroidal anti-inflammatory drugs may need to be switched in order to find the optimal mix of pain relief and minimal side effects for a given patient (see Table 1). As pain intensifies and becomes moderate to severe, the addition of weak opioids in combination with acetaminophen will be indicated. Examples are acetaminophen with codeine, oxycodone, or hydrocodone (Tylenol #3, Percocet, Vicodin). At this pain level, adding

adjuvant analgesics will help reduce the need for rapid escalation of opioid doses.

ADJUVANT ANALGESICS

Adjuvant analgesics are drugs developed for other than pain indications, yet have pain-relieving properties that may be utilized for treating cancer pain. Adjuvant analgesics are corticosteroids, tricyclic antidepressants, anticonvulsants, antihistamines, anxiolytics, and neuroleptics. Corticosteroids work by reducing edema produced by tumors on surrounding organs and by reducing swelling pressure on nerves. Corticosteroids are particularly helpful for brain metastases with cerebral edema, spinal cord compression from epidural metastases, neuropathic pain from metastatic compression or infiltration, metastatic bone pain, hepatic capsular distention, and symptomatic lymphedema. Doses of dexamethasone, 1 mg to 2 mg three times daily, are usually sufficient. Dexamethasone 100 mg intravenously is occasionally used for acute cord compression or plexopathies. Corticosteroids also often improve appetite and mood, as well as promote a general sense of well-being. Tricyclic antidepressants inhibit transmission of pain sensation in the spinothalamic tracts by augmenting norepinephrine and serotonin in the pain-modulating descending spinal pathways. Amitriptyline is the most often used tricyclic antidepressant, best started with a small dose of 10 mg, and increased every three or four days until optimal adjuvant analgesia is obtained without significant side effects. Final dosage will range from 25 mg to 150 mg per day. Desipramine and nortriptyline are often used because they are less sedating. Analgesic effect is seen in seven to 10 days,

but may take weeks to become maximal. Since at least 25% of cancer patients suffer from depression, tricyclic antidepressants will benefit these symptoms as well. About 60% of patients will experience pain relief from tricyclic antidepressants (see Table 2).

The anticonvulsant drugs carbamazepine, phenytoin, and valproic acid stabilize nerve membranes and are effective for lancinating neuropathic pain. Anticonvulsant drugs are generally effective at smaller doses than needed to prevent seizures. Begin carbamazepine at 100 mg twice a day and gradually increase to 200 mg three times a day if needed. Phenytoin can be initiated at 100 mg twice a day and increased if necessary. Assessing serum levels may be helpful at high doses to arrive at optimal doses without incurring significant side effects. Anxiolytics, such as lorazepam, help with anxiety and often produce an amnesiac mental state. They effectively relieve the pain of muscle spasm. Neuroleptics, such as haloperidol, are particularly effective for confusion, hallucinations, and delirium, which are common in hospice patients. Methotrimeprazine is analgesic and antiemetic, as well as neuroleptic. Antihistamines are analgesic, antiemetic, and sedative. Parenteral hydroxyzine at 100 mg is equianalgesic to 10 mg of parenteral morphine.

OPIOIDS

When pain becomes severe, the strong opioids are necessary, while nonopioid analgesics and adjuvant analgesics are continued. Strong opioids are morphine, hydromorphone, methadone, and levorphanol. Whereas there are ceiling doses for nonsteroidal anti-inflammatory drugs and dose limits of acetaminophen-opioid combinations because of potential hepatic toxicity, there is no ceiling dose for strong opioids. The correct dose of strong opioids is the dose that renders the patient essentially pain-free with a minimum of adverse side effects. In hospice, the usual goal is comfort rather than function, and more side effects are allowed. Constipation is universal with opioids, and patients never become tolerant

to this side effect. Stool softeners and laxatives are begun concomitantly with opioids. An example would be Senokot-S, two to eight tablets a day. Nausea occurs in 10% to 40% of patients given opioids, but tolerance develops rapidly and prophylactic antiemetics are not necessary. For the small number of patients with persistent opioid-induced nausea and vomiting, prochlorperazine or metoclopramide is usually effective. The sedative side effect of opioids lasts only two or three days and usually requires no treatment. Occasionally, dextroamphetamine or methylphenidate is given to help alleviate sedation when higher doses of opioids are necessary. Respiratory depression is exceedingly rare in hospice patients treated chronically with opioids. If an overdose has been taken but the patient is arousable, the next dose of opioid is withheld. If the patient is severely obtunded and is experiencing symptomatic respiratory depression, naloxone is given in small intravenous doses so as not to precipitate recurrence of pain; 0.04 mg is given as often as every minute until the respiratory rate normalizes. Naloxone has a much shorter half-life than

the opioids, especially the long-acting preparations. Sometimes a constant infusion is necessary. Meperidine (Demerol) often has side effects of tremor, myoclonus, and seizures after more than 250 mg is taken parenterally in 24 hours. Demerol also has a ceiling dose of analgesia and is not used in hospice.

Intolerable side effects from one opioid analgesic can often be overcome by switching to an alternate opioid. This may be because different opioids affect different opioid receptors. Excessive adverse effects from the dose of morphine necessary to relieve pain can sometimes be obviated by switching to hydromorphone or methadone, which should be initiated at 75% of the equianalgesic dose because of incomplete cross tolerance.

Morphine is the strong opioid of first choice in hospice. It is readily available in multiple dose forms (oral, rectal, sublingual, intravenous, subcutaneous, and epidural). Morphine's action is familiar to physicians and nurses and has become accepted by patients and families. The recommended beginning dose of morphine for moderate to severe cancer pain in

Table 1

Nonsteroidal anti-inflammatory drugs

Drug	Dose range
Ibuprofen (Matrin)	400 mg PO q 4 h 600-800 mg PO q 6-8 h
Indomethacin (Indacin)	25-50 mg PO q 6-8 h
Ketalarac (Taradal)	30 mg IM q 6 h 10 mg PO q 6 h
Flurbiprofen (Ansaid)	100 mg PO q 8-12 h
Diflunisal (Dolabid)	500 mg PO q 8-12 h
Naproxen (Naprasyn)	250-500 mg PO q 8-12 h
Choline magnesium trisilicate (Trilisate)	1500 mg PO q 8-12 h
Sulindac (Clinaril)	150-200 mg PO q 12 h

the opioid-naïve patient under age 65 is 30 mg orally every four hours non-prn (20 mg for older patients).¹ The dose can be increased by 30% to 50% every four hours until optimal pain relief is achieved or intolerable side effects occur. Daily morphine doses are generally in the range of 100 mg to 500 mg orally, although doses of thousands of milligrams per day are not uncommon.

Once pain relief is achieved and

Table 2

*Tricyclic antidepressant
adjuvant analgesics*

Drug	Usual starting dose (mg)	Usual effective dose range (mg)
Amitriptyline	10-25	50-150
Imipramine	10-25	50-150
Doxepin	10-25	50-150
Desipramine	10-25	50-150
Nortriptyline	10-25	50-100

Table 3

Equianalgesic opioid doses

Opioids	P.O. dose (mg)	I.V. dose (mg)
Morphine	30.0	10.0
Methadone	20.0	10.0
Hydromorphone	7.5	1.5
Levorphanol	4.0	2.0
Oxycodone	30.0	—
Codeine	200.0	130.0
Meperidine	300.0	75.0
Pentazocine	180.0	60.0

the opioid dose is relatively stable, long-acting dose forms are more convenient for both the patient and the caregiver. ORAMORPH SR or MS CONTIN will usually be effective for 12 hours so that administration is necessary only twice a day. Likewise, long-acting fentanyl skin patches may be more convenient once the opioid dose is stable. Analgesia from a single patch usually lasts 72 hours so that patients with vomiting or bowel obstruction, or those for whom oral opioids are otherwise inappropriate, may benefit from the DURAGESIC patch, which can be changed every three days (it is occasionally necessary to change every two days). A fentanyl patch of 50 micrograms per hour equals 75 mg per day of oral morphine or 25 mg per day of parenteral morphine.² Be aware of the patch pharmacodynamics: onset of analgesia four to eight hours, peak effect, 17 hours, and half-life after removal of 17 hours. Additional dosing of an immediate-acting opioid such as morphine or hydromorphone may be necessary every four hours prn breakthrough pain. The breakthrough pain dose is equal to one-third of the every 12-hour long-acting dose. For patients using the fentanyl patch, 15% of the equianalgesic daily morphine dose may be given every four hours prn breakthrough pain.

If breakthrough pain doses are needed three or more times a day, an increase in the long-acting dose is indicated. An additional dose similar to the breakthrough pain dose is also given in anticipation of incident pain. Such pain may occur upon changing positions, walking, or defecating.

Parenteral analgesia may be necessary for patients unable to swallow or needing rapid increases in opioid dose because of very severe pain. Typically, parenteral opioids are given by constant intravenous or subcutaneous infusion. Bolus parenteral dosing tends to cause peak-level side effects and trough-level pain recurrence. Intramuscular injections are painful and have bolus-type adverse effects and, therefore, are not used in hospice.

Changing from oral to parenteral opioid dose and from one opioid to

another is expedited by referring to equianalgesic tables (see Table 3). If the patient has been receiving 180 mg of long-acting morphine every 12 hours, the equivalent intravenous dose is one-third as much or 120 mg per day given as 5 mg per hour by constant infusion. The three-to-one ratio of oral to parenteral morphine is followed because the liver immediately removes two-thirds of the oral dose. Breakthrough pain doses during constant infusion therapy are usually 25% of the hourly dose given every 15 minutes as needed. In this case, 1.25 mg morphine every 15 minutes prn breakthrough pain. Again, if three or more breakthrough pain doses are needed within a two-hour period, the hourly dose should be increased to the total dose that has been given per hour over the two-hour period.

ANESTHESIA AND SURGERY

An estimated 10% to 15% of hospice patients with cancer pain will be refractory to opioid adjuvant drug analgesia or experience intolerable side effects necessitating regional anesthesia, most usually epidural administration of morphine or fentanyl, often combined with the anesthetic MARCAINE. Because only 10% of the parenteral opioid dose is given epidurally for an equal analgesic effect, the side effects of sedation, confusion, and nausea are proportionately less. Epidural opioid administration is also more effective than systemic opioids for neuropathic pain. Rarely, neurosurgical procedures such as cordotomy and dorsal rhizotomy are necessary for refractory pain.

Some hospice patients suffering from recalcitrant pain will benefit by administration of intravenous barbiturates, methotrimeprazine, and ketamine. These drugs will deeply sedate the patient, resulting in pain relief otherwise unobtainable.

MISCELLANEOUS THERAPIES

Although opioid drugs are the mainstay analgesic therapy for cancer pain in hospice, multiple additional concomitant nonopioid therapies are not only indicated but also are necessary for optimal patient care. Radiother-

apy is often more effective than opioids for bone metastases. The radioisotope strontium 89 may be given intravenously and subsequently will emit beta particles within bone, affecting metastatic deposits and reducing bone pain. Biphosphonate drugs such as pamidronate are given intravenously to stop osteoclastic activity and relieve bone pain. Celiac plexus block for pancreatic cancer and trigger point injections are frequently very beneficial.

Occasionally, surgical intestinal bypass for bowel obstruction is indicated. Transcutaneous electrical nerve stimulation and acupuncture are often helpful adjuncts.

THE HOSPICE TEAM

Of central importance in hospice care is the team interaction with the cancer patient and family. More often than not, psychosocial and spiritual issues are barriers to optimal pain relief. The work of nurses, social workers, and chaplains attempting to resolve long-standing psychosocial and spiritual dysfunction is invaluable in achieving pain relief. Frequently, the hospice team will observe opioid dose reduction by up to tenfold as these types of problems are resolved, despite no change in the physical status of the patient's cancer.

TOLERANCE AND ADDICTION

Most frequently, an increase in intensity of pain for the cancer patient means growth of the cancer. Although opioid tolerance does occur, tolerance is never the driving force for rapid escalation of opioid dosage. Concern regarding tolerance should not deter the patient or physician from initiating opioid treatment of pain early in the course of the cancer process if medically indicated for satisfactory pain relief. Fear of addiction should not be a deterrent to early and complete pain relief for the cancer patient. These patients don't hoard their prescriptions, obtain prescriptions from multiple physicians, or

use illegal drugs. Cancer patients don't experience the psychic high with opioid administration that characterizes the addict. In a large prospective study over a 10-year period, only four cases of iatrogenic addiction occurred among 11,882 medical patients who had no history of addic-

chological assessment and support. Relaxation, distraction, massage, heat, and transcutaneous electrical nerve stimulation enhance analgesia and optimize the function of the hospice patient with cancer pain. Regional anesthetic techniques, such as epidural opioid administration and celiac plexus block, along with neuroablative procedures, such as rhizotomy and cordotomy, are available for the occasional patient who does not achieve satisfactory pain relief without intolerable side effects from systemic analgesic therapy. When all members of the caregiving team contribute, remission of the patient's pain and suffering is achievable. MM

John Manion is an oncologist with Minneapolis Medical Specialists in Robbinsdale and practices at North Memorial Medical Center. He has served as the hospice medical director at North Hospice since its inception in 1979.

RESOURCES FOR THE PHYSICIAN

- Agency for Health Care Policy and Research, Cancer Pain Management Panel. Management of cancer pain. Washington, D.C.: U.S. Department of Health and Human Services, 1994. Clinical Practice Guideline Number 9.
- Coyle N, Adelhardt J, Foley KM, Portenoy RT. Character of terminal illness in the advanced cancer patient: pain and other symptoms during last four weeks of life. *J Pain Symptom Manage* 1990;5:82-93.
- Doyle D, Hanks G, MacDonald N. Oxford textbook of palliative medicine. New York, New York: Oxford University Press, 1993.
- Patt RG (ed). Cancer Pain. 1st ed. Philadelphia: J.B. Lippincott, 1993.
- Wall PD, Melzack R (eds). Textbook of pain. 3rd ed. Edinburgh, Scotland: Churchill Livingstone, 1994.

tion and who had received at least one opioid dose during a hospitalization.³ Clinical experience caring for the cancer pain patient in the hospice setting affirms the very low risk of addiction.

CONCLUSION

In hospice, the axiom is "pain is what the patient says it is." A careful and thorough medical and psychosocial history and physical examination become the basis for diagnosis and treatment regarding the cancer pain. The patient's own words define the pain intensity. Visual analogue or 10-point verbal pain scales quantify the intensity and help communication between patient and physician. Opioid and adjuvant analgesics are the mainstay of cancer pain treatment. All patients benefit from psy-

REFERENCES

1. U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research. Management of cancer pain: clinical practice guidelines. Rockville, Maryland: Department of Health and Human Services, 1994. AHCPR Pub. No. 94-0592.
2. Physician Education Committee, Minnesota Cancer Pain Initiative. Basic Concepts in the Management of Cancer Pain [Lecture series]. Minneapolis (located at the Virginia Piper Cancer Institute): Minnesota Cancer Pain Initiative, 1992.
3. Porter J, Jick H. Addiction rare in patients treated with narcotics [Letter]. *N Engl J Med* 1980;302:123.

The Medical Futility Debate Continues

The courts have avoided answering directly whether physicians are obligated to provide futile medical treatment when requested, so the debate is shifting to medical and lay communities.

Margo S. Struthers, J.D., and Brad C. Olson, J.D.

The medical and ethical debate about whether physicians are obligated to provide "futile" medical treatment continues. Initially, the debate centered primarily on ethical principles, such as individual patient and physician decision-making autonomy. However, as managed care becomes more prevalent and as more providers and hospitals take on risk through capitation, broader societal issues such as rationing or resource allocation may affect the definition of futile treatment and the determination of whether physicians are obligated to provide such treatment. Court cases have failed to completely resolve the issues involved, so some communities have initiated projects intended to define futile treatment and develop treatment guidelines.

Court Cases

Courts are beginning to address, at least tangentially, physicians' legal obligation to provide futile medical treatment. One such example is the case of Ryan Nguyen¹ in Spokane, Washington. Ryan Nguyen was born six weeks premature on October 27, 1994, after experiencing severe fetal distress. He was treated for hypoxia/acidosis and was suffering from a bowel obstruction and serious kidney problems requiring acute peritoneal dialysis.^{2,3} Physicians also suspected he suffered brain damage. Because of the bowel obstruction and other medical complications, two hospitals contacted by Sacred Heart

Medical Center refused to accept Ryan as a candidate for their chronic renal dialysis programs prior to eventual kidney transplant.³ It was the opinion of the treating physicians that Ryan was not, and would never be, an acceptable candidate for chronic renal dialysis or for a kidney transplant. Furthermore, the treating physicians believed that Ryan's condition was universally fatal, his life expectancy was very limited, and at some point in the near future he would suffer from an infection, such as peritonitis, and die.³ Thus, according to media reports, physicians at Sacred Heart Medical Center believed that continued kidney dialysis and life support for Ryan was "futile" and was "cruel and inhumane" because the treatment subjected Ryan to "substantial pain and suffering without hope."^{4,5} As a result, the hospital attempted to convince Ryan's parents that continued dialysis treatment should be stopped.

Ryan's parents believed that dialysis treatment should be continued, and on November 22, 1994, they obtained a temporary restraining order requiring the hospital to continue dialysis and, pending a permanent injunction hearing, requiring the hospital to take "whatever immediate steps [are] necessary to stabilize and monitor the life of Ryan Nguyen."⁵ The permanent injunction hearing took place on December 12, 1994, but before the judge issued a ruling on whether the hospital must continue dialysis and other treatment,

Ryan was transferred to another hospital that agreed to treat him, thus rendering the case moot.⁶

As the Nguyen case demonstrates, medical futility cases typically involve a family member or other surrogate requesting that life-sustaining treatment be continued and a physician who believes the treatment should not be initiated or should be terminated because it is "futile." Medical futility cases are essentially the converse of "right-to-die" cases, which generally involve a family member or surrogate who requests that life-sustaining treatment be terminated, while the physicians or other clinicians believe treatment should be continued.

To date, no court in the United States has directly addressed the issue of whether physicians have a duty to offer treatment they consider futile. However, in 1992 a British court of appeals held that physicians have the right to refuse to provide life-sustaining treatment if such failure to treat is in accordance with the physician's best clinical judgment.⁷ This case, entitled *In re J.*, involved a 16-month-old child who suffered an accidental fall when he was one month old and sustained a head injury resulting in severe disability, both mental and physical. The child was severely microcephalic and epileptic. Physicians agreed that the child was unlikely to develop much beyond his then current level of functioning, and they predicted deterioration of his condition and a short life expectancy.

The local governmental authority, which shared parental responsibility with the mother, initially obtained a court order requiring the child's physician to initiate artificial ventilation and other life-saving measures should the child suffer a life-threatening event. The treating hospital appealed the decision and the court of appeals held that as long as those with parental responsibilities consent to the child being treated at a particular health facility, then the treating physician at such health facility must be allowed to treat the child in accordance with his or her best clinical judgment, even if those persons with parental responsibilities do not agree that treatment should be withheld or withdrawn.

In the United States, several courts have resolved medical futility cases without addressing directly the physician's obligation to provide futile medical treatment. Rather, these courts have resolved the cases by making a legal determination with respect to other issues, such as whether an independent decision maker should be appointed when a family requests continued treatment; whose decision a hospital must abide by when parents do not agree on whether to continue treatment for their child; and whether terminating or withholding treatment would violate state or federal statutes.

One case that focused on who the appropriate decision maker should be when determining whether life-sustaining treatment should be continued is the Minnesota case *In re the Conservatorship of Helga M. Wanglie*.⁸ The Wanglie case, which has been commented on extensively, was one of the first to bring the issue of futility to national attention. Mrs. Wanglie was 87 years old, respirator-dependent, and in a persistent vegetative state. Her physicians at Hennepin County Medical Center requested that life-sustaining treatment be withdrawn since the treatment was not benefiting her. Mrs. Wanglie's family insisted that treatment be continued. HCMC sought appointment of an independent conservator to decide whether the treatment should continue. The probate court held that Mr. Wanglie was the

appropriate decision maker for his wife and that there was no need for an independent conservator.

Another case that involved futility issues but did not specifically resolve a physician's obligation to provide futile medical treatment is *In re Jane Doe*.⁹ Decided by the Supreme Court of Georgia in July 1992, the Jane Doe case involved a 13-year-old

“No clear consensus
exists among
medical, ethical, or
legal experts about
what constitutes
futile medical
treatment.”

child diagnosed with a condition varying between stupor and coma states. The attending physicians, the hospital's bioethics committee, and two physician consultants all shared the view that withdrawal of life support and a do-not-resuscitate order were appropriate. The mother also agreed with this conclusion; however, the father did not.

The hospital petitioned the court to permit withdrawal of treatment. The basis for the request was that treatment was abusive and inhumane. However, unless both parents agreed to such action, the trial court refused to permit the hospital to carry out a DNR order. The court stated that it must yield to the presumption in favor of life when parents do not agree on terminating life support.

On appeal, the only issue the Supreme Court of Georgia addressed was whether the hospital had to abide by the mother's decision or the father's decision. The court, in affirming the trial court decision, held that because the father did not consent to a DNR order, the hospital was prohibited from taking such action. The *Jane Doe* case, both at the trial and appellate level, is evidence that courts may hold that hospitals cannot with-

draw futile medical treatment without obtaining consent from either the patient, the patient's family, or other appropriate surrogate.

Another recent case has received considerable attention in the popular media and legal, medical, and ethical literature, even though it did not directly address a physician's obligation to provide futile medical treatment. The Virginia case, entitled *In the Matter of Baby K*,¹⁰ involves an infant girl born with anencephaly. Baby K has been in and out of the hospital because of respiratory distress. Baby K's mother refused to consent to a DNR order, despite a request from the treating physicians and Baby K's father. Thereafter, the hospital sought a declaratory judgment establishing that the hospital's refusal to provide Baby K with life-supporting medical care in the future would not violate the Emergency Medical Treatment and Active Labor Act (EMTALA), the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), the Child Abuse Amendments of 1984, or the Virginia Medical Malpractice Act.

In July 1993, the district court held that withholding ventilator treatment from Baby K would violate EMTALA, the Rehabilitation Act, and the ADA. The court declined to rule on whether withholding life-sustaining treatment would violate the Child Abuse Amendments or the Virginia Medical Malpractice Act. The court cited constitutional principles of family autonomy and the presumption in favor of life as further justification for its decision that the hospital must provide ventilator treatment to Baby K.

On appeal, in a 2-1 decision in February 1994, the United States Court of Appeals for the Fourth Circuit upheld the lower court decision that EMTALA required the hospital to provide respiratory support to Baby K when she arrived at the hospital in respiratory distress. Because of the infant's extremely limited life expectancy and because any treatment would be futile, the hospital argued that the prevailing standard of medical care for infants with anencephaly is to provide only warmth,

nutrition, and hydration. Therefore, a requirement to provide respiratory assistance to Baby K would exceed the prevailing standard of medical care, according to the hospital.

The Fourth Circuit concluded that the language of EMTALA is plain and unambiguous and requires the hospital to provide stabilizing treatment for an emergency medical condition. The court stated that EMTALA does not provide an exception to the duty to provide stabilizing treatment when such treatment would exceed the prevailing standard of medical care. A dissenting judge reasoned that Congress would not have attempted to impose federal control over decisions involving terminally ill patients in circumstances such as Baby K's. Rather, this judge concluded, the statute should only be applied to "patient dumping" of indigent or uninsured patients in emergencies, the evil to which it was directed. The Fourth Circuit did not address possible violations of the ADA or the Rehabilitation Act, since the issue was resolved by its interpretation of EMTALA.

Defining Futile Treatment

Case law addressing a physician's obligation to provide futile medical treatment will continue to evolve. If a court in the United States ever explicitly addresses the issue of whether physicians have an obligation to provide futile treatment, it probably also will have to address whether the medical treatment in question is "futile." To date, no clear consensus exists among medical, ethical, or legal experts about what constitutes futile medical treatment. Generally, the existing definitions of futility center on the goal of the medical therapy at issue and the benefit a patient can gain from the therapy.¹¹ There also is debate about who should be involved in the process of defining futile treatment.^{12,13} Possible participants include professional medical associations, hospitals, third-party payers, legal and ethical experts, and the general public. Furthermore, once a definition of futility is developed and agreed upon, applying the definition and determining whether the treatment in question constitutes futile

treatment will almost certainly need to be addressed. Again, there has been considerable debate on the proper role of the patient, the patient's family or other surrogate, the attending physician, physician consultants, and an institution's ethics committee, as well as debate on the amount of weight that should be given to these persons' respective points of view.

Community Initiatives

In addition to the few cases that have begun to appear in the courts, the debate on futility has been heightened recently by certain communities' attempts to define futility and to develop guidelines that health care providers can follow. One approach to defining futile treatment centers on obtaining input from both the medical and lay communities. Such an approach is currently being undertaken in Denver, Colorado.¹⁴ In the Denver initiative, referred to as "Guidelines for Use of Intensive Care in Denver," or the "GUIDE" project, most Denver-area health care institutions are working together to draft guidelines on futile care, with input from insurers, legal experts, and others. These guidelines eventually will be shared with the public in hopes of achieving a consensus about what medical treatments Denver-area health care providers will consider to be futile and, therefore, presumably refuse to provide.

Whether the GUIDE project will be successful remains to be seen. There is concern that implementation of the futile care guidelines may violate the ADA.¹⁵ Outside of the futile care debate, there has been discussion that terminating treatment being delivered to any incompetent patient may violate the ADA, even when a family has consented to such termination and physicians agree that to do so is medically appropriate. Such a legal obstacle is certainly a possibility and is reinforced by the trial court's decision in the *Baby K* case, discussed above, which held that withholding ventilator treatment from Baby K would violate the ADA.

Another project concerning "futility" policies has recently been initiated by the Minnesota Center for

Health Care Ethics. According to Dorothy Vawter, the center's associate director, the project's initial goal is to identify the range of policies and guidelines concerning medical futility currently in effect in 30 health care institutions in Minnesota. Other plans include determining why institutions may have different policies or guidelines and determining a consensus, if any, on when a health professional is justified in refusing to honor a request for a medically futile intervention or whether community-wide guidelines on medical futility are appropriate or feasible. Ultimately, the project's goal is to develop one or more ethically defensible model policies addressing medical futility that are helpful to health care professionals and institutions, as well as the patients they serve. The project is funded by a grant from the Medica Foundation's Project DECIDE (Discussion of Evolving Choices In Dying and Ethics).

Conclusion

The debate regarding futile medical treatment will continue to evolve on a variety of levels, involving ethical, medical, legal, social, and technological issues. Medical and lay communities will probably continue to develop futility guidelines. Numerous factors could affect the substance of the guidelines developed. Initiatives, such as that undertaken in the Denver area, are attempting to arrive at a societal consensus about when sustaining biological existence should no longer be pursued. Whether such a consensus will withstand possible legal challenges remains to be seen. ■■

Margo Struthers is a partner and Brad Olson is an associate attorney with Oppenheimer Wolff & Donnelly in Minneapolis.

REFERENCES

1. In re Ryan Nguyen, Case No. 94-2-06074-5, Superior Court, State of Washington, County of Spokane.
2. In re Ryan Nguyen, Petitioner Nguyen's Brief Supporting Motion for Injunction at p. 1.
3. In re Ryan Nguyen, Sacred Heart Medical Center's Brief at p. 2, 6.
4. Jewell M. Judge asked to keep infant on

life-support. The Associated Press 1994 Dec. 13.

5. Associated Press. Parents don't want plug pulled on critically ill baby. Seattle Times 1994 Nov. 25; Sect. B:5.

6. Jewell M. Critically ill Spokane baby transferred to Portland hospital. The Associated Press 1994 Dec. 13.

7. In re J. (a minor child), 3 W.L.R. 507 (Eng. C.A. 1992).

8. In re the Conservatorship of Helga M. Wanglie, No. PX-91-283, Minn. 4th Jud. Dist., Probate Court (1991).

9. In re Jane Doe, 418 S.E. 2d 3 (Ga. 1992).

10. In the Matter of Baby K, 832 F. Supp. 1022 (E.D. Va. 1993), aff'd, 16 F.3d 590 (4th Cir. 1994), cert. denied, 115 S. Ct. 91 (1994).

11. Judith F, Daar A. Clash at the bedside: patient autonomy v. a physician's professional conscience. Hastings Law Journal 1993;44:1253.

12. Veatch RM, Spicer CM. Medically futile care: the role of the physician in setting limits. Am J Law Med 1992; 18(1 and 2):15.

13. Miles SH. Medical futility. Law Med Health Care 1992;20(4):310.

14. Gianelli DM. Getting a better fix on futility. Am Med News 1994 Dec. 5:3.

15. Gianelli DM. One community looks for consensus on futile care. Am Med News 1993 Sept. 20:1.



Family Practice & Psychiatry

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 150 professionals who offer care at 9 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441
EOE

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care - at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183

ANNOUNCEMENTS

• • • • •

MMA DAY AT THE CAPITOL IS MARCH 30

Mark your calendar for MMA Day at the Capitol on March 30. This important opportunity to talk to legislators will be held at the capitol and at the Kelly Inn in St. Paul.

• • •

MN PHYSICIANS SUPPORT SERVICES NEEDS VOLUNTEERS

The MN Physicians Support Services program, under the auspices of the Minnesota Physicians Foundation, is introducing a peer support network for physicians facing professional malpractice claims. This new program is seeking physicians—especially from Greater Minnesota—who are willing to provide peer support. For more information about the program, or to volunteer, call Katherine Kennedy at 612/378-1875 or 800/999-1875.

• • •

HOW DOES CULTURAL DIVERSITY AFFECT PATIENT OUTCOMES?

Find out at the conference "Through the Eyes of Others: Is Health Care Culturally Competent?"

February 24, 1995

8 a.m. to 5 p.m.

Earle Brown Continuing Education Center, St. Paul

The keynote speaker is Lonnie Bristow, M.D., president-elect of the American Medical Association. This continuing education conference for physicians is sponsored by the Hennepin County Medical Society, United Way of Minneapolis Area, Hennepin County Medical Center staff, and the University of Minnesota. For more information, call Nancy Bauer, 612/623-2893.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Introduces Quality and Coverage Bill

"This is an unprecedented reconvening of the MMA House of Delegates," said Andrew J. K. Smith, M.D., MMA president, opening a special meeting to consider the MMA Quality and Coverage Act on January 7. "We are not so much angry as frustrated about the direction of health system reform. We don't want to throw everything out, but we do want to make those changes that will be best for our patients. Some things in MinnesotaCare—like RAPO—just don't make sense. The government should have a role in regulating the market, but it should not become the market."

After much discussion and the addition of a few amendments, the MMA House accepted the Board of Trustees' draft of the bill. Some important issues will be addressed in separate legislation in order to keep the bill sharply focused. (See page 39.)

Immediately following the meeting, the MMA rushed to prepare the bill for introduction. Sen. Sheila Kiscaden, IR-Rochester, and Rep. Thomas Huntley, DFL-Duluth, have introduced the bill. A folder of information, including a bill summary, talking points, a sample letter to the editor, a sample letter to legislators, and a pocket card of talking points are in the mail to MMA spokespersons and leaders.

The MMA bill addresses these problems:

- Consolidation of power in the hands of a few huge health plans threatens to erode the state's high

quality of health care and rob our patients of their ability to choose a physician.

- The state plans to set up a highly regulatory and unnecessary system of health care delivery.

- Despite the MinnesotaCare program, there are still 400,000 Minnesotans who are uninsured at some time during each year.

The Quality and Coverage Act offers these solutions:

- Make health plans accountable for preserving quality and choice in the competitive market.

- Let competition, NOT unnecessary regulation, hold down costs. Repeal RAPO. Reform professional liability law. Strengthen public safety laws.

- Enact a "fair share" penalty on state taxes and a higher cigarette tax to move closer to universal coverage, end cost shifting, and make insurance reforms possible.

As the House prepared to adjourn, past president Robert D. Christensen, M.D., called for a round of applause for Timothy Crimmins, M.D., chair of the MMA Board of Trustees, Andrew J.K. Smith, M.D., president of the MMA, and Paul Sanders, M.D., chief executive officer. Calling the MMA's development of the Quality and Coverage Act an "outstanding performance," Christensen went on to say, "We are really winners. In introducing this bill, we are acting as our patients' advocates in the socioeconomic arena, as we do every day in the medical arena."

• • • • •

Quality and Coverage Act

The MMA Health Care Quality and Coverage Act would shift the state from a regulatory to a competitive system, move toward universal coverage, make health insurance more affordable, preserve Minnesota's high quality of health care, and keep decisions about medical care in the hands of patients and their physicians.

Coverage

Although it may not be possible to achieve 100 percent success, the MMA believes the state should keep its commitment to achieving universal coverage in 1997. If most people have health insurance, insurance reforms will be possible, cost shifting will end, and a competitive rather than a regulatory system will hold down costs.

Provide Incentives

The MMA Quality and Coverage Act calls for a "fair share" penalty to encourage people to buy health insurance. People without insurance would lose their personal income tax deductions.

Make Insurance Affordable

MinnesotaCare law requires pure community rating by 1997. The Quality and Coverage Act would allow premiums to vary on the basis of age to make insurance more affordable for young people.

The MMA supports the insurance reform provisions due to take effect July 1, 1997. (See page 35.) Unless the state comes close to achieving universal coverage, however, such reforms could backfire and serve as incentives to put off buying insurance.

Fund MinnesotaCare Subsidies

The Quality and Coverage Act would fund the MinnesotaCare program for the low-income uninsured through a cigarette tax increase of 40 cents per pack every year for five years, raising the current tax of 48 cents per pack to \$2.48. This tax

would raise approximately \$100 million in its first year and nearly \$500 million at the end of five years.

The 2 percent tax on health care services would sunset July 1, 1997, when the cigarette tax would bring in enough money to fund MinnesotaCare. The unpopular 2 percent tax does not raise enough money to fund universal coverage, falls on those who need medical care, and is difficult to administer. MMA policy calls for repeal of the 2 percent tax, but in the current political climate, immediate repeal is considered impossible.

The Quality and Coverage Act would prohibit the transfer of funds from the Health Care Access Fund into the General Fund. Currently, \$25 million to \$35 million in health care funds flow into the General Fund each biennium.

Cost Containment

The MMA Quality and Coverage Act would set a level playing field on which the competitive marketplace could control costs. It would also achieve cost containment through professional liability reforms and through stronger public safety measures. Laws calling for unnecessary state regulation of health care delivery would be repealed. Scarce state money would be devoted to subsidizing care for the uninsured rather than paying for an expensive bureaucracy.

Repeal RAPO

The MMA bill would repeal the provision in MinnesotaCare law requiring that after July 1, 1997, all health care not delivered through integrated service networks (ISNs) or community integrated service networks (CISNs) must be delivered through the regulated all-payer option (RAPO). The bill would delete all references to RAPO and allow HMOs, co-ops, indemnity plans, and medical savings accounts, as well as ISNs and CISNs, to compete in the marketplace.

Set Standard Health Plan Regulations

The Quality and Coverage Act would set standard regulations for all health plans, including HMOs, ISNs, CISNs, co-ops, and indemnity insurance companies. If purchasers are able to compare a similar product, the competitive market will hold down costs.

The MMA bill proposes that the Recodification Task Force set the following standards, which would apply equally to all health plan companies:

- a standard medical benefits set that could be offered with several different cost-sharing options, such as copayments and deductibles;
- standard insurance reforms, including those slated to take effect July 1, 1997;
- financial solvency requirements, which may include a risk-based capital mechanism;
- data reporting and health plan report card provisions;
- participation in the Minnesota Comprehensive Health Association;
- participation in risk adjustment;
- requirements that health plans provide a complaints process, advocacy services, and information about ways to access services;
- requirements that health plans have enough providers to serve the geographical area; and
- prohibitions of unfair competition, such as the misleading use of the term "provider" in marketing information.

Reassess Growth Limits

The bill calls for a reassessment in 1997 of the need for the 10 percent limit on revenue and expense increases for providers and health plans. After 1997, the state will have moved closer to universal coverage and the health plans, regulated by the same rules, will be competing on the basis of access, cost, choice, and consumer satisfaction. At this point, competition should control costs and make growth limits unnecessary.

At the meeting of the House of Delegates, some physicians ques-

tioned why the MMA didn't call for the immediate repeal of expenditure limits. Andrew Smith, M.D., president of the MMA, said that with health care costs going down, the expenditure limits will probably be a moot point anyway and it would be more politically acceptable to let them continue for three years. "The repeal of RAPO will be an easier sell with expenditure limits in place," he said.

Encourage Medical Savings Accounts

Contributions to medical savings accounts (MSAs) would be deductible from state income taxes. Money in an MSA at the end of the year could remain there to be used the next year.

An MSA is a method for individuals to fund their health care. The employee uses the cash in the MSA to pay for health expenses. Unspent balances could be invested and accumulate earnings that are tax deferred.

The MSA concept was added to the bill by the MMA House of Delegates in an amendment submitted by Kenneth Heithoff, M.D. Heithoff said it was a virtual certainty MSA legislation would be adopted at the federal level. William Jacott, M.D., AMA trustee, said the AMA supports the MSA concept and intends to include it in the revised Patient Protection Act.

Reform Professional Liability Law

The MMA bill would enact the following reforms based on the California Medical Injury Compensation Reform Act (MICRA):

- cap non-economic damage awards at \$250,000;
- repeal the requirement that the plaintiff's attorney must receive a 15-day notification before the physician/defendant can consult with the defense attorney;
- reform joint and several liability laws;
- set sliding-scale cap on attorney contingency fees related to the size of the award;
- require periodic payments for large awards;

MinnesotaCare Insurance Reforms

• • • • • MINNESOTA CARE legislation has already instituted the insurance reforms outlined below.

Limits on pre-existing conditions

Current MinnesotaCare law limits pre-existing condition limitations in the small group and in the individual market to a one-time, 12-month exclusion. A complete ban on pre-existing limitations and exclusions takes effect in 1997.

Guaranteed issue and renewal

In the small business market (two to 29 employees), insurance carriers currently may not refuse to issue or renew policies to any company willing to pay the premiums. They must treat all the employees as a group rather than carving out individual policies or referring individuals to the Minnesota Comprehensive Health Association. In

the individual market, renewal is currently guaranteed, and in 1997, issuance will be guaranteed as well.

Rating Bands

Insurance premiums may not vary because of gender. The amount that premiums may differ because of health risk are limited by rating bands that will be reduced annually until July 1, 1997, when everyone must be charged the same premium amount for a particular health coverage product. Medicare supplementary plans currently must be community-rated.

Portability

Insured individuals may move from public programs to private health plans, and from one product to another within a health carrier's business, without restrictions or exclusions. In 1997, individuals will be guaranteed the ability to move from one insurance carrier to another.

- mandate offsets for collateral payment sources to prevent double recovery from insurance or other sources and then from a malpractice award.

Encourage Public Safety

Health care costs can be reduced by preventing injuries. The MMA bill calls for these new safety laws:

- Failure to use a seatbelt would be a primary offense punishable by a \$100 fine;
- Failure to wear a helmet when riding a motorcycle, snowmobile, or all-terrain vehicle would be a misdemeanor punishable by a \$25 fine;
- Bicyclists would be required to wear helmets.

Assure Quality Improvement

The Quality and Coverage Act would assure that cost containment efforts

do not erode quality of care and would require plans to give the public more information so they can make informed decisions. The bill would also direct the state data collection efforts toward continuous quality improvement rather than cost containment.

Preserve Quality and Access

The bill includes the following provisions:

- No health plan may design a provider network, policies on access to providers, or marketing strategies in a way that would discourage the enrollment of high-risk patients. Provider networks must not omit or severely limit providers who specialize in caring for patients with expensive chronic conditions or whose

Q&C continued on page 36

Q&C continued from page 35

practices focus on ethnic minorities. Violations will be enforced as unfair trade practices by the Department of Commerce or the Department of Health.

- No health plan may give financial rewards to providers based on the number of services they request or the number of referrals they deny. (This provision would not prohibit capitation or other compensation methods that hold providers accountable for the cost of caring for an entire patient population.)

- Health plans must pay for bona fide emergency care for enrollees even if care is provided outside the network. The plan could require patients to be transferred to network hospitals as soon as they were stable.

- No prior authorization may be required for emergency care.

- Health plans must participate in the financial risk adjustment system being developed by the state so that plans with a high proportion of high-risk patients will not be at a competitive disadvantage.

- Minnesota's utilization review (UR) laws must be revised to make sure that utilization review is not used to prevent patients from receiving medically necessary services. Actively practicing physicians must be involved in developing utilization review criteria, based on sound clinical principles, and these criteria must be updated at least every year. Current law requires UR organizations to provide access to review staff "during normal business hours." The MMA bill would extend access to seven days a week and after business hours. The protection in Minnesota's UR law would be extended to managed care delivered in the workers' compensation program.

Preserve Choice

The bill includes the following provisions:

- All health plans must offer a point-of-service option that would allow people to seek medical care from any health care providers re-

gardless of whether they are in the plan's network and regardless of specialty. Health plans must offer this point-of-service choice in all segments of the market—large group, small group, and individual—during the open enrollment period. The price of the point-of-service option must be approved as "actuarially justified" by the commissioner of commerce or by the commissioner of health.

- Every purchasing pool with more than 1,000 insured enrollees must offer at least three types of health plan products. If three options are not possible in a particular geographic area, the pool must offer as many options as possible.

Require Plans to Disclose Information

To help consumers make an informed choice about which health plan to join, all health plans would be required to disclose the following information in their action plans, in addition to the data required by

existing law:

- A description of their utilization review practices, policies, and criteria. Under current law, only the treating provider is entitled to receive written criteria, and then only after a request for certification has been denied. The Quality and Coverage Act would make the criteria available to enrollees and providers at all times.

- A list of any types of providers or services that enrollees can use only if they are referred by a gatekeeper; a description of the types of providers authorized to act as gatekeepers; and the policies governing when and whether referrals will be given.

- A description of the role of patients and health care providers in governing and operating the health plan, including the role of actively practicing providers in determining the health plan's medical policies regarding quality improvement, practice parameters, coverage decisions,

Public Supports Tobacco Tax to Fund Care for Uninsured

• • • • • THE TOBACCO TAX Initiative of the Smoke-Free 2000 Coalition held a news conference January 12 to announce the results of a poll showing that 65 percent of Minnesotans approve of tobacco taxes as a way to finance the MinnesotaCare program. The tobacco tax was the only funding source to win majority support. The 1994 survey of 613 Minnesota households was conducted by Mathematica Policy Research, Inc. The MMA is an active member of the Tobacco Tax Initiative, which was founded to support a tobacco tax increase to fund MinnesotaCare and anti-smoking educational programs. A. Stuart Hanson, M.D., represented the MMA at the news conference.

"Three thousand young people will start smoking for the first

time today. One out of every three of them will die of tobacco related illness," said coalition spokesperson Ruth Parriott. "A higher tobacco tax is the single most effective way to prevent kids from smoking," she said. A 10 percent increase in the price of tobacco results in a 12 percent decrease in smoking among youth, according to a U.S. General Accounting Office report on teenage smoking.

A higher tobacco tax has worked in Canada. In the 1980s, Canada reduced its teen smoking rate by two-thirds by raising its tobacco tax and increasing its preventive health education efforts. In 1979, 46 percent of Canadian teens were smokers, and by 1991, this proportion had fallen to only 16 percent.

and utilization review.

- An explanation of how their provider network design, their policies on access to providers, and their marketing strategies address and do not discourage enrollment and access to care for high-risk and special-needs enrollees.

Current law requires plans to provide information about credentialing, the number and type of network providers, and policies to address the needs of high-risk and special-needs patients.

Encourage Continuous Quality Improvement

The MMA Quality and Coverage Act would make sure that state data initiatives are used for continuous quality improvement rather than for cost containment and would improve coordination and communication among the various state entities dealing with data collection.

Under the Quality and Coverage Act, the Minnesota Health Data Institute would remain a public/private partnership between the Min-

nesota Department of Health and a board representing providers, purchasers, and payers. The 20-member Data Institute board of directors would gain two new members, including the chair of the Health Technology Advisory Committee (HTAC) and an additional physician member.

The Data Institute would be responsible for collecting data to help the health plans conduct continuous quality improvement, and for developing health plan report cards and consumer satisfaction surveys. In addition, the Data Institute would establish the policies for data collection, analysis, confidentiality, and disclosure for all data not associated with the public health initiatives of the Minnesota Department of Health (MDH). The MDH would collect financial data and the data needed for population-based studies.

Data privacy provisions would be strengthened by requirements to encrypt names of both providers and patients.

All plans to develop state practice parameters that would confer absolute defense in malpractice lawsuits would be repealed and the Practice Parameter Advisory Committee (PPAC) disbanded. This would allow health plans and physician organizations greater flexibility.

The Health Technology Advisory Committee, the Health Data Analysis Unit, and the Information Clearinghouse (renamed the Health Information Library) would be under the auspices of the Data Institute.

Define Role of RCBs

The Quality and Coverage Act defines a role for the Regional Coordinating Boards (RCBs). The RCBs would advise the Minnesota Health Care Commission, as well as the commissioner of health. To strengthen ties to the commission, an RCB Overview Committee would be created, which would include the RCB chairs and two commission members. In addition, one RCB chair would serve on the commission.

• • • • •

A N N O U N C E M E N T S

DR. BIRKEY ELECTED TRUSTEE

The MMA House of Delegates elected Thomas Birkey, M.D., of Montevideo as a trustee from the Southwest District, replacing Richard Mulder, M.D., who has left his position on the Board to serve in the Minnesota House of Representatives. The House of Delegates gave Dr. Mulder a round of applause, and House Speaker Barbara Yawn, M.D., noted that this was a very pleasant reason to have to replace a trustee.

• • • • •

RESTRUCTURED COMMITTEES IN THE HOUSE

House committees dealing with

health care have been restructured this year. The House Health and Human Services Committee is chaired by Rep. Bob Anderson, DFL-Ottertail. The MinnesotaCare Division of this committee is chaired by Rep. Roger Cooper, DFL-Bird Island, and the Human Services Finance Division is chaired by Rep. Lee Greenfield, DFL-Minneapolis.

The Senate committees are unchanged from last year. The Senate Health Care Committee is chaired by Sen. Linda Berglin, DFL-Minneapolis, the Family Service Committee by Sen. Pat Piper, DFL-Austin, and the Health Care and Family Services Finance Division by Sen. Don Samuelson, DFL-Brainerd.

• • • • •

MEDICAL RECORDS NOTICE

A law that went into effect July 1, 1994, requires physicians to furnish patients with written notice about who can gain access to information in their health records. This notice may be posted in the office or included with the patient and resident bill of rights. A draft notice, developed by the commissioner of health, was published in the November issue of *Minnesota Medicine*. Since the final notice has not yet been published in the *State Register*, physicians should continue to use this draft notice. If you have any questions, contact Mary Prentnieks at 612/378-1875 or 800/999-1875.



Viewpoint

• • •

Timothy J. Crimmins, M.D.
Chair, MMA Board of Trustees

What Should Government's Role Be?

After the collapse of President Clinton's attempt to pass a health system reform bill, the words "less government" are heard almost as often as "no new taxes."

But the government does have a legitimate role to play in preserving public health. It is important to define exactly what that role is—at the national, state, and local levels.

Here are some of my ideas about how government can guarantee consistent, fair standards without becoming overly involved in the private delivery system.

At the federal level, there should be national insurance regulations. Currently, large corporations that operate across state lines find it difficult to deal with a myriad of different state regulations. People who travel or change jobs and move across the country worry about losing health insurance. There should be clear national standards that are reasonably uniform and fairly enforced across all 50 states. Among them should be a standard medical benefits set.

One of the most pressing needs for change at the national level is for changes in the Employee Retirement Income Security Act (ERISA) laws. ERISA is a major stumbling block to state attempts at health system reform. This federal law shields companies that are self-insured from state regulation or taxation of their em-

ployee health benefits plans to help pay for care for the uninsured. ERISA laws should be changed to give states some control over the self-insured companies and to allow states to become the testing ground of reform. Minnesota and several other states have requested ERISA waivers, but state-by-state changes through individual waivers would be hard on businesses that operate nationwide. There should be federal changes in ERISA.

Another important change needed at the national level is adequate funding for the Medicare program. As the baby-boomers approach the brink of Medicare eligibility, the country will no longer be able to afford to provide health insurance for a rapidly growing elderly population. The only alternative to deep cuts is a gradual phase-in of means testing for Medicare, as the AMA advocates. Medicare should be a safety net, not a competitor in the private market.

At the state level, the MMA's Quality and Coverage Act calls for the state government to subsidize insurance coverage on a sliding scale for low-income people and set uniform standards to assure quality and maintain a level playing field on which health plans can compete. In addition, the state government's role in regulating the insurance industry needs to be clarified. Who should regulate insurance products—the Department of Commerce or the De-

partment of Health? Right now the lines of responsibility are not clear.

The most important role for the state is its traditional responsibility to protect the public health. The state must preserve air, water, and food quality, as well as maintain a high level of vigilance against infectious diseases. In this age of international travel, infectious diseases have the potential to spread very rapidly. Tuberculosis and measles are still threats. Plague has recently been reported in India. We have the capability to prevent and treat epidemics, but we must be vigilant. In recent years, the state has shifted some of its emphasis to health system reform. It's time to shift back to its primary focus on public health. The state has set admirable epidemiological goals for the year 2000, which should be pursued. These include studies of disease prevalence and a health census that would demonstrate physician accomplishments, as well as areas of medical need.

The state also has an important responsibility for public education on health and safety issues. Minnesota has a good track record. Our state has taken on the powerful tobacco lobby and enforces strong clean air legislation. But we cannot let down our guard. Minnesota slipped from its position as healthiest state in the nation in 1994 because the smoking rate increased and is now slightly above the national average of 23 percent. Traffic fatalities are up this year, as are snowmobile deaths. Violence in the home continues to be a problem especially for women and children. The state has a responsibility to investigate possible dangers, to protect the vulnerable, and to develop community-based solutions to reduce risks.

At the local level, government has a responsibility to provide safety net services. Active community health boards should give information to state planners so that resources can be provided to match local needs and to address unique local problems.

The solution is not less government, but a clearer focus on the proper role of government. • • • • •

What's In? What's Out?

The MMA House of Delegates wrestled with the problem of crafting a Quality and Coverage bill that would have a realistic chance of passage and yet would include the most important objectives of the association.

Public Safety

Delegates debated the wisdom of including public safety provisions that would be sure to arouse strong opposition, but concluded that, as a matter of principle, physicians should stand up for strong seat belt and helmet laws. "We've encountered opposition from the motorcyclists before, and it hasn't been a pretty sight," said Kent Wilson, M.D., "but this is a statement of principle." The House amended the bicycle helmet provision, expanding it to apply to all bicyclists rather than just to minors.

Antitrust Relief

The need for antitrust protection for physicians in small clinics who are negotiating with large plans is critical. The House of Delegates decided to deal with this issue in separate legislation rather than including an antitrust provision in the Quality and Coverage bill for the following reasons:

- An antitrust provision would arouse too much opposition among potential allies who may help pass the Quality and Coverage bill.

- MinnesotaCare law includes an antitrust exemption that is viewed as a model for other states. This law allows collaboration if the parties can demonstrate "sufficient professional and economic integration."

- Additional antitrust exemptions in Minnesota law won't do any good unless there are changes in federal law. The AMA is working at the federal level to change antitrust laws.

The House of Delegates approved legislative language that would allow clinics with 20 or fewer physicians to collectively bargain without any economic or professional integration if they are dealing with pay-

ers that have 100,000 or more enrollees.

Medicare Balance Billing

The MMA opposes state limitations on Medicare balance billing that are more stringent than the federal limits. The House of Delegates decided that repeal of the state balance billing law should be pursued as a separate bill mainly because it will generate fierce opposition from the Senior Federation and because legislators are reluctant to take on this issue.

Geographic Inequities

The House of Delegates decided that correction of geographic inequities in Medicare and Medicaid reimbursement should also be pursued separately. The MMA will seek legislation calling for geographic equity in General Assistance Medical Care and Medicaid capitation rates and will seek an appropriation from the 1995 Legislature to enable the attorney general to initiate legal action against the federal government to correct the geographic inequity in Medicare reimbursement rates under both fee-for-service and capitated arrangements. The MMA has already begun to discuss these issues with legislative leaders.

Surcharge

A call for repeal of the \$400 surcharge on physicians' medical licenses is not included in the MMA bill because it is not part of MinnesotaCare legislation. The original purpose of the surcharge was to maximize the amount of matching money from the federal government for Minnesota's Medical Assistance program and increase physician reimbursement, but many physicians doubt that it benefits them. The MMA is seeking information from the Department of Human Services on how much of the surcharge money actually comes back to physicians as increased Medicaid reimbursement. It is difficult to track this money because it goes into the General

Fund. The MMA is pursuing this issue separately.

House Refers Issues to Board of Trustees

The MMA House referred several issues regarding the Quality and Coverage Act to the MMA Board of Trustees. Among them was an amendment that would require physicians conducting utilization review to be licensed in the state of Minnesota. Rep. Richard Mulder, M.D., said he will be co-sponsoring a bill in the Legislature to accomplish this purpose, so it isn't necessary to include it in the MMA bill. William Jacott, M.D., AMA trustee, said the AMA is rethinking this complex issue in the light of the growing use of telemedicine, and he didn't think it was appropriate to include it in the MMA bill at this time. "Soon doctors in Hawaii may be reading x-rays for those in Florida," Jacott said.

Another amendment that was referred to the Board would "limit the discretionary power of the commissioner of health." Delegates discussed the problem of having both the Department of Health and the Department of Commerce regulating insurance products.

The House also recommended that the Board study the tax penalty provision in the Quality and Coverage Act and consider the possibility of phasing it in over a one- or two-year period. Some physicians expressed concern that a penalty geared to the income tax would not have enough impact on low-wage earners. Others were concerned it would penalize the working poor. The tax penalty is meant to drive people who can't afford insurance into the MinnesotaCare program or other public assistance programs. An amendment calling for state funding to pay for staff for the regional coordinating boards was also referred to the Board for further study.

• • • • •

LEGAL NEWS

HCFA Is ENFORCING SELF-REFERRAL BAN

Despite the fact that final rules have not yet been promulgated, on January 1, 1995, the Health Care Financing Administration began enforcing the strict new Omnibus Budget Reconciliation Act of 1993 (OBRA-93) physician referral law, sometimes called the Stark II law after its author Rep. Fortney Stark, D-Calif.

The new law extends the prohibition against physician self-referral, which previously applied only to clinical laboratory services, to the following designated health services: physical therapy services; occupational therapy services; radiology or other diagnostic services; radiation therapy services; the furnishing of durable medical equipment; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

If a physician or any member of his or her immediate family has a financial relationship, either an ownership interest or a broadly defined "compensation arrangement" with an entity, then the physician may not make a referral for designated health services reimbursable by Medicare. The entity may not submit a claim to the Medicare program, or to any other person or payer in certain circumstances, for designated health services rendered to a patient who was referred by a physician who has such a financial relationship.

Unlike the anti-kickback provisions of the Medicare and Medicaid fraud and abuse statute, a violation of Stark II does not require an improper intent. A misunderstanding could lead to significant penalties. Civil penalties include denial of payment, a fine of up to \$15,000 for each

service, or exclusion from the Medicare program for the person submitting the claim. The penalty for scheming to circumvent the referral ban are civil fines of \$100,000 and exclusion from Medicare.

The new law lists a number of exceptions to the self-referral ban. One such exception is for health services provided in a rural area if substantially all the services are for people living in the rural area. An article in the March issue of *Minnesota Medicine* will summarize the provisions of the Stark II legislation and will include the full list of exceptions.

MARSHFIELD CLINIC WILL APPEAL ANTITRUST JUDGMENT

A U.S. District Court in Wisconsin has ordered the Marshfield Clinic to pay a \$48-million antitrust judgment to the state's largest health insurer, Blue Cross and Blue Shield United of Wisconsin.

The clinic immediately announced plans to appeal the verdict, which held that the Marshfield Clinic had created a health care monopoly in central and northern Wisconsin. The jury agreed with the Blue Cross and Blue Shield contention that the clinic had fixed prices, driven independent physicians from the region, and excluded competing health maintenance organizations from the market.

The jury awarded Blue Cross and its HMO, Compcare, \$16.1 million. The damages are tripled in an antitrust case, bringing it to \$48 million.

The Marshfield Clinic president, Richard Leer, expressed confidence that the verdict would be overturned on appeal to the Seventh Circuit Court of Appeals in Chicago. In the meantime, he said, Marshfield Clinic "will continue to care for the people we serve, both here in Marshfield and at each of our centers designed

to provide care locally." The clinic operates 233 satellite health care centers and has a network of 430 doctors.

U.S. District Judge John Shabaz said he would rule March 16 on a Blue Cross and Blue Shield request that Marshfield Clinic divest itself of its satellite centers. If this request is upheld, Leer said, the clinic would have to sell some buildings, potentially reducing the availability of care.

NEWBORN TESTING LAW CHANGED

During the 1994 session of the Minnesota Legislature, the state law concerning testing of newborns for hemoglobinopathy, phenylketonuria, and other errors of metabolism was amended. As a result of this amendment, religious tenets and practices are no longer a basis for exemption from the required testing.

The Monitor

FEBRUARY 1995

...

PRESIDENT*Andrew J.K. Smith, M.D.***CHAIR, BOARD OF TRUSTEES**
*Timothy J. Crimmins, M.D.***CHIEF EXECUTIVE OFFICER**
*Paul S. Sanders, M.D.***DIRECTOR, COMMUNICATIONS**
*Mark S. Vukelich***EDITOR**
Lorrie Holmgren

...



ntroducing, the only auto leasing and purchasing company solely dedicated to serving the health care market.

ne year ago, Minnesota Medical Services Resources, a business corporation owned by the Minnesota Medical Association and Hennepin County Medical Society, has committed to health care professionals to be the premier provider of products and services that are of high quality and value. As part of our ongoing fulfillment pledge, we have leased to the newest member of the Minnesota Medical Services Resources, MMBR Motor Services.

MMBR MOTOR SERVICES

MMBR Company

by the members of

MA and HCMS.

Here's what MMBR Motor Services is committed to doing for you:

When you call us, we go to work providing free consultation to help you outline your needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and all models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle.

Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease, or following the purchase of a new vehicle, we will arrange to have your vehicle professionally detailed, assuring high resale value by keeping your

vehicle in like-new condition.

We provide complete support after the lease/purchase. If you have a question, call us.



Remember, this service comes to you from MMBR, your association owned business corporation, so you can be confident in the knowledge that we have worked on your behalf to select the best company to be our partner. For personal attention on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 1/800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.

URGENT CARE OPPORTUNITIES

Group Health, Inc.

Group Health, Inc. is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24 hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, or 1-800-472-4695, or send CV to: **Group Health, Inc.**, Physician Services, Attn: Ann Johnson, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



*Group Health is part of the
HealthPartners family of health plans.*

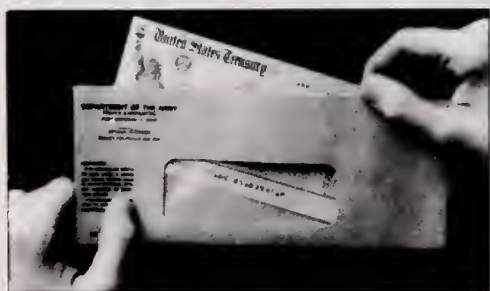
EO/AA Employer



HealthPartners

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor.

CALL COLLECT CPT. RICK OTTO
612-854-7702

ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®

Lessons from the Butcher Case

*Third-party interests, not the patient's,
inappropriately forced this family into court to
discontinue their son's medical treatment.*

Barbara J. Blumer, J.D.

When Jim and Pattie Butcher decided to discontinue artificially administered nutrition and hydration for their 34-year-old son, Jamie, who had been in a permanent vegetative state for almost 17 years, they did not expect to be thrust into legal proceedings, and certainly not into the headlines. They had always made health care decisions for their son, as most families do, without being appointed legal guardians. They had sought all available rehabilitative treatment and were involved in Jamie's care every day, even while he lived in a nursing home. Their decision was consistent with prevailing medical standards in Minnesota and across the nation for patients in a permanent vegetative state. In making their decision, they had adhered to every principle of responsible health care decision making, consulting every person they knew who had an interest in and concern for Jamie. During that process, no one questioned their decision, because all who knew Jamie agreed that it was appropriate for him.

The Butchers were thrust into litigation and the limelight by others acting in their own interests, not Jamie's.

The Story

Jamie Butcher was a 17-year-old high school senior when he sustained severe brain injuries in an auto accident. He never regained consciousness and, after extensive treatment, was diagnosed to be in a permanent

vegetative state. He did not require assistance with respiration but was given nutrition and hydration through a gastrostomy tube.

His parents cared for him in their home for seven years. At one point, Jamie suffered a cardiac and respiratory arrest, which the Butchers had fully anticipated would be the way his life would end. After calmly washing Jamie and changing his gown, Pattie called 911 to report his death. However, with no home-based "do-not-resuscitate" order system in place,¹ Pattie was soon met with determined, and ultimately successful, resuscitation efforts by the 911 responders.

The Butchers placed Jamie in a nursing home in 1984 but continued to be very involved with his care and treatment. Pattie assisted with Jamie's care almost every day. She became a member of the nursing home's ethics committee and a facility volunteer in other capacities. The Butchers never became legally appointed guardians or conservators for their son, since every health care professional with whom they dealt recognized them as appropriate surrogate decision makers. Their other son, Jeff, also recognized them as appropriate decision makers, although he felt that artificial nutrition and hydration should have been discontinued years earlier.

In 1993, the Butchers came to the decision that artificially administered nutrition and hydration should be discontinued and that Jamie should be allowed to die from the effects of

his 1977 auto accident. They felt he should not live in the vegetative state longer than he had been fully alive and that they had been keeping him alive so long primarily for their own benefit, not his. As the Butchers came to their decision, they discussed the matter with every person who had an interest in and concern for Jamie. They contacted family members from grandparents to cousins, Jamie's friends from grade school and high school, and significant health care professionals who cared for Jamie. Jamie's attending physician was supportive of the family's decision and was prepared to supervise his care after discontinuing treatment. No one involved with Jamie expressed any reservation about the Butchers' decision on Jamie's behalf or about the appropriateness of the Butchers making the decision for Jamie.

The Butchers brought the matter to the nursing home's ethics committee, saying that they intended to take Jamie home when they discontinued treatment so that he could die at home surrounded by family and friends. The ethics committee was composed of nursing home staff and the facility's in-house counsel. The committee did not express any concern from an ethical perspective with the Butchers' decision or with the appropriateness of the Butchers making the decision on Jamie's behalf. However, the ethics committee did note concerns about the nursing home's legal position under the Minnesota Vulnerable Adult Act,² fear-

ing that the discontinuation of treatment might be viewed by authorities as "neglect." If it were deemed neglect that the nursing home failed to report, the nursing home could be subject to licensure sanctions. Therefore, the committee recommended that authorities be notified, in essence suggesting the nursing home report the Butchers for suspected illegal neglect. Legal counsel also noted that Ramsey County should be apprised so that it could have an opportunity to intervene by seeking the appointment of a guardian, even though there were no indications that anyone had any medical or ethical concerns about the substance of the Butcher's plan.

The ethics committee also suggested that Jamie be re-evaluated for confirmation of the diagnosis of permanent vegetative state. There was no indication that the diagnosis was in any doubt after 17 years, nor was there indication in the minutes of what purpose this re-evaluation would serve. However, wanting to be cooperative, the Butchers took Jamie to Hennepin County Medical Center, where he had been previously evaluated. Jamie's diagnosis was confirmed, and the Butchers became reacquainted with Ronald Cranford, M.D., of the neurology department, to discuss their decision to discontinue treatment.

Since the nursing home intended to report the Butchers to the authorities, the Butchers contacted Ramsey County on their own before arranging to bring Jamie home. They wanted the county to have all relevant information before it took a position on the issue, and they did not want to take Jamie home and find the authorities at their doorstep with legal papers. The county received complete information concerning Jamie's condition, including his recent re-evaluation and pertinent medical-ethical guidelines concerning withdrawal of medical treatment for persons in a permanent vegetative state. The county was also given the opportunity to discuss the matter with Cranford.

The Ramsey County Attorney's Office did not take much time to reach the simple conclusion that discontinuation of artificial nutrition

and hydration was failure to provide "necessary food" since it would result in Jamie's death and, therefore, that it was illegal neglect under the Vulnerable Adult Act. If the Butchers were to withdraw treatment, they could be subjected to criminal penalties for neglect. This interpretation was given regardless of the fact that medical treatment is discontinued

"A legal process does
not add anything to
the health care
decision-making
process when there
are no disagreements
among those
involved."

daily, including the withdrawal of artificially administered nutrition and hydration, in Ramsey County as a matter of standard medical practice in appropriate cases and that no one had, to anyone's knowledge, been faced with a neglect charge under those circumstances. Ramsey County suggested that, for their own protection, the Butchers could proceed to court to be appointed conservators for Jamie and ask for court authorization to discontinue treatment. The county also suggested that there would be no opposition by the county to their petition.

The Butchers were in a quandary. On the one hand, they were being told that withdrawal of treatment was illegal neglect, which could subject them to criminal penalties, even though similar decisions were being made by families for their loved ones every day in Ramsey County, throughout Minnesota, and across the country, consistent with good medical practice, without sanction, and without court involvement. On the other hand, they were also being told that, if they just went to court to be appointed conservators for Jamie and received authorization to with-

draw treatment, the withdrawal of treatment would suddenly not be considered neglect—as if the court's blessing would transform what the county thought was an illegal act into a legal one.

Rather than taking the easy path to resolve their legal dilemma—by being appointed conservators for Jamie and obtaining court "protection"—the Butchers decided to resolve it by bringing a head-on challenge to Ramsey County's unrealistic and unprecedented interpretation of the Vulnerable Adult Act. By so doing, they would be able to have the court find that they were not "neglecting" their son and would also be able to help other families faced with similar decisions; perhaps Ramsey County would not accuse other families of illegal neglect or force them into court to be appointed conservators for loved ones when no one who knew the patient questioned the appropriateness of their decision.

On February 18, 1994, the Butchers filed a Declaratory Judgment Action against Ramsey County and asked for two rulings:

- first, that withdrawal of artificially administered nutrition and hydration, consistent with prevailing medical practice, does not constitute neglect under the Vulnerable Adult Act even if it results in the patient's death; and
- second, that they, who had been recognized and respected surrogate decision makers for Jamie for his entire life, again consistent with prevailing medical practice, need not be appointed his conservators in order to make this last health care decision on his behalf.

With no dispute about the facts of the case, Referee and Court Commissioner James R. Finley of the Ramsey County District Court made his decision based on stipulated facts, legal briefs, and oral arguments. Ramsey County made a motion that a guardian ad litem be appointed to represent Jamie. The Butchers argued against that motion on the grounds that a guardian ad litem could not add anything to the proceeding in these circumstances, even though in other cases the appointment of a guardian ad litem would be

appropriate. The only questions to be determined were legal questions, and Ramsey County could be counted on to vigorously represent the public interest and public policy. Furthermore, since Jamie had never been conscious as an adult, he had never been able to formulate or express any preferences about his health care treatment that the guardian ad litem could express. His medical condition was not in dispute, nor was there any dispute about the support of his family, friends, and medical advisers for the decision. Anything the guardian ad litem might say would be mere speculation and conjecture, when everyone who knew him agreed on the appropriateness of the Butchers' decision.

On September 7, 1994, Referee Finley issued his order.³ He found that a "decision to continue or terminate artificial administration of nutrition and hydration is a health care and ethical decision," that "termination of artificially administered nutrition and hydration for a person in a permanent vegetative state is within the scope of accepted medical and ethical practice in Minnesota," and that it is not neglect under the Vulnerable Adult Act.

He also found that the Butchers were appropriate surrogate decision makers for their son, that they were not required to be appointed guardians or conservators, and that there was no need for a court order authorizing the termination of artificial administration of nutrition and hydration. Referee Finley found that "this is a private health care and ethical decision to be made by plaintiffs after consultation with James D. Butcher II's health care providers and immediate family members." He did not appoint a guardian ad litem to represent Jamie in the legal proceedings. He went on to refer with approval to numerous medical-ethical guidelines developed by health care professional organizations. He found that recognition of the Butchers as surrogate decision makers for Jamie without court involvement is consistent with the standard of medical and ethical practice in Minnesota and that there is no provision in Minnesota law that requires the appoint-

ment of a guardian or conservator under these circumstances.

A few days after the court's order, Ramsey County announced that it would not appeal, leaving the Butchers free to implement their decision. The Butchers began preparing themselves to take Jamie home and discontinue treatment. They decided to wait a few weeks so that Jamie's brother, Jeff, could return from Europe to be there when Jamie died.

The last day before the expiration of the 30-day automatic stay of the court's order, two groups filed petitions seeking to have a guardian ad litem appointed for Jamie, the same issue Ramsey County had raised and the court had denied. The petitioners, Arc Minnesota, Inc., and the Ethics and Advocacy Task Force of the Nursing Home Action Group, had been aware of the litigation since it was filed but had made no previous attempt to become involved. They had no personal connection with Jamie or the Butcher family. They were represented by local counsel and by the National Legal Center for the Medically Dependent and Disabled, Inc., from Indianapolis, Indiana.

The Butchers were concerned about other legal actions the petitioners might take because they knew that the National Legal Center had obtained emergency legal control of patients in other states when families sought to discontinue treatment under similar circumstances. Therefore, they brought Jamie home a few days after the motions were filed.

On the day of the hearing, Arc of Minnesota voluntarily dropped its petition. The Ethics and Advocacy Task Force maintained its petition to have a guardian ad litem appointed and also asked that the entire case be dismissed. Its reasons for seeking dismissal were not made entirely clear, but seemed to focus on a desire to eliminate the case as a precedent for other patients and families, particularly persons with extensive disabilities.

Referee Finley heard the petitions on October 17, 1994, and from the bench ordered that the petitions be dismissed. He ruled that he had pre-

viously decided the guardian ad litem issue after full consideration and that the petitioner had no standing to bring what were essentially motions for reconsideration or appeals of previously determined issues.

The Butchers held a brief religious ceremony in their home when they terminated Jamie's artificially administered nutrition and hydration on October 19. He died peacefully 11 days later.

The Ethics and Advocacy Task Force has pursued further legal review with another Ramsey County District Court judge. As *Minnesota Medicine* goes to press, no ruling has been issued. The Task Force's first allegation in its review papers is that the court violated the Task Force's "statutory right to advocate on behalf of vulnerable persons" by denying its petition to have a guardian ad litem appointed.

Significance to Health Care Professionals

There are important lessons to learn from the Butcher case.

First, it appears that consideration of the nursing home's legal position diverted the ethics committee from its focus on the ethical issues involved in the Butcher family's situation. This case illustrates the ease with which discussions of ethics are overwhelmed by discussions of legal liability. Ethics committees should not be the place in which a health care facility's legal decisions are made; when they are, true value to the institution is greatly diminished.

Second, both the nursing home and Ramsey County appeared to act under single-dimensional analyses of the legal issues and forced the Butchers into legal proceedings for their own protection rather than Jamie Butcher's protection. Neither appeared to consider that decisions to terminate medical treatment, whether it be something as dramatic as withdrawing artificially administered nutrition and hydration or something as mundane as discontinuing an antibiotic, happen hundreds of times every year in Minnesota, in hospitals, nursing homes, and

clinics, in accordance with prevailing standards of medical care when treatment offers insufficient likelihood of benefit to the patient. A simplistic determination that a health care treatment or artificially administered nutrition or hydration is "necessary" under the Vulnerable Adult Act if death results in its absence flies in the face of logic and other laws, such as the living will and health care power of attorney statutes.⁴ Hundreds of Minnesota families and their physicians and other health care providers would be criminals if that were a reasonable interpretation of the Legislature's intent in creating the law. Health care providers and government must carefully evaluate the laws under which they operate to avoid forcing patients and families into court for the protection of the institutions rather than the patients.

Third, the Butcher case illustrates the importance of professional guidelines for health care decision-making issues. As had many other judges across the country, Referee Finley gave considerable weight to guidelines from the American Medical Association, the Minnesota Medical Association, and other professional groups on the issues presented. In the absence of a Minnesota law prohibiting families from making decisions when there is no dispute, Referee Finley looked to the professional guidelines for articulation of community practice. He stated that health care decisions are medical and ethical decisions to be made by appropriate decision makers in consultation with their health care advisers. Even for patients incapable of making their own health care decisions, most decisions, including those related to termination of treatment, do not involve legal issues with which courts need be involved.

A legal process does not add anything to the health care decision-making process when there are no disagreements among those involved. Courts are often used to rubber-stamp appropriately made health care decisions because families, guardians, health care providers, or government seek protection from some unarticulated, and largely illusory, legal exposure. Courts should be, and are,

available to resolve disputes between patients and families, or between patients/families and health care providers, when disagreements or other circumstances dictate the need for impartial third-party review and issue resolution. The practice in many counties in Minnesota to seek court orders for medically and ethically appropriate termination of treatment should be carefully scrutinized under the principles emphasized by Referee Finley in the Butcher case.*

Fourth, the Ethics and Advocacy Task Force's attempt to become involved further illustrates how easy it is to be diverted from considering the patient's interests. During the hearings, the Task Force's counsel repeatedly stated that it did not disagree with the decision the Butchers were making for Jamie, yet it asserted a right as an advocacy group, not acquainted with Jamie or his family and not representing any specific clients or patients, to have its say on legal issues already determined by the court. Even after Jamie's death, it persists in the litigation, arguing its own alleged "statutory right to advocate on behalf of vulnerable persons" as its primary concern. To his credit, Referee Finley was not diverted from his thoughtful analysis, and his approach should be noted in other situations as well.

A Look to the Future

The Butcher case has already had an impact on laws concerning health care decision making in Minnesota. A task force led by the Minnesota Office of the Attorney General has drafted new language intended to revise the Vulnerable Adult Act to clarify that appropriate withdrawal

of health care treatment does not constitute "neglect." The Vulnerable Adult Act may be amended in the 1995 legislative session, and the proposal should be watched carefully.

Discussion continues about whether Minnesota should enact a health care decision-making act, such as exists in many other states, to establish a statutory hierarchy of decision makers for patients who do not have guardians or conservators and who have not formally appointed surrogate decision makers through a living will or a health care power of attorney. Such a law would relieve the uncertainty many families, health care professionals, and legal professionals face about who are appropriate surrogate decision makers for incapable patients. However, there is concern that a health care decision-making act would confer authority upon family members high on the statutory hierarchy when, in fact, they are not the most appropriate decision makers for the patient in the context of overall family or personal relationships. The Minnesota Medical Association guidelines⁵ recognize the responsibility of physicians to identify the appropriate surrogate decision maker for each patient in the context of the patient's entire family and personal relationships. Patients may not be well served by enactment of a rigid statutory hierarchy that could replace physician judgment. MM

Barbara Blumer is an attorney with Orbovich & Gartner with offices in St. Paul and Eagan. She was one of the attorneys for Jim and Pattie Butcher.

REFERENCES

1. Blumer BJ. Communicating DNR orders in non-hospital settings. *Minn Med* 1994; 77(4):41-3.
2. *Minn. Stat.* § 626.557.
3. James D. Butcher and Patricia A. Butcher v. Thomas Fashingbauer, et. al, Ramsey County District Court, File Number C7-94-1717, Findings of Fact, Conclusions of Law and Judgment dated September 7, 1994.
4. *Minn. Stat. Ch.* 145B and 145C.
5. Minnesota Medical Association. Policy Compendium, 1994 ed. Minneapolis: Minnesota Medical Association, 1994:41-3.

* See also: In re the Guardianship of Arthur Voeller, Ramsey County District Court Civil File No. Co-94-3874, Findings of Fact, Conclusions of Law and Judgment dated March 23, 1994, in which Referee Finley found that a guardian need not receive court approval for a decision to terminate treatment when there was no disagreement concerning the appropriateness of the decision. ["There are no judicial issues to be decided."]

An Opportunity That Speaks for Itself

"We are three Board Certified Otolaryngologists located in an affluent suburb of Minneapolis seeking another physician to join our practice."

"Working in five suburban locations provides a flexible schedule, a varied patient population, an opportunity to build a lucrative practice and the time to do the other things that are important to you."

MINNEAPOLIS OTOLARYNGOLOGY HEAD AND NECK SURGERY, P.A.

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
(612) 885-6224 or 1-800-842-6469



IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



**Central Minnesota
Group Health Plan**

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE



Make plans to be at C.F. Anderson's Casino & Product Fair

April 13, 1994

Thunderbird Motel, Bloomington

- | | |
|---------------|-------------|
| ♥ Roulette | ♦ Auction |
| ♠ Blackjack | ♣ Good food |
| ♣ Dice games | ♠ Seminars |
| ♦ Door prizes | ♥ Exhibits |

Watch for your invite!

You are always a winner!



Death, Science, and God: A Review of Three Books

*Will scientific understanding allow us to
master our destiny? Do we want it to?*

Charles R. Meyer, M.D.

Death has changed. The family gathered at the deathbed is a rare portrait in this age of ventilators and CPR. Daniel Callahan of The Hastings Center in his book "The Troubled Dream of Life" calls death of yesteryear "tame death" or "peaceful death." Its demise has stemmed from technology, which has stretched out our dying and snatched it from the quiet of home and transplanted it into the whirl of the ICU. Callahan describes not only how technology has altered the dying process, but also what it has done to our collective feelings about our mortality. Technology has not assisted our adjustment to mortality, and Callahan offers wise counsel on re-adjusting our views.

Medical technology has led us to believe we can control nature and master our destiny. The undisputed progress of 20th century medical science has fostered an arrogance rooted in what Callahan describes as two "illusions of mastery": 1) that we can master the body by technology, and 2) that we know ourselves well enough to know when to give up the struggle against death. The religion of scientific truth prophesies that the same methods that conquered tuberculosis and determined the structure of DNA will relentlessly uncover the secrets of all diseases, stem the ravages of aging, and challenge death itself. According to Callahan, this doctrine invokes both the "moral logic

Reviews:

"The Troubled Dream of Life: Living with Mortality," by Daniel Callahan, Simon and Schuster, 1993.

"Dreams of a Final Theory," by Steven Weinberg, Vintage, 1992.

"The Astonishing Hypothesis: The Scientific Search for the Soul," by Francis Crick, Scribners, 1994.

of medical progress" and "medical brinkmanship." According to the moral logic of medical progress, what can be known should be known and what can be done should be done. Thus, "if we do not pursue the conquest of disease, we are open to moral blame." Our aim is control of disease, life, and death. Brinkmanship is the term Callahan uses to describe the shifting line between life and death. Medicine has been tempted to a game of chicken, getting as close as possible to that line with interventions and treatments before pulling back and admitting defeat.

From the wheel to the A-bomb, humans have had to change their thinking as science has changed their world. We seldom have done a sterling job of adapting and rarely have understood the process while it was happening. Infamous statements of

omniscience from scientists speak eloquently of our misplaced hubris. (Philip Jolly in 1875 advised his student Max Planck not to study physics since there was nothing left to be discovered.) Callahan fears we may have lost our perspective on what science and technology can and should do for us. Should there be limits to what scientific inquiry tries to answer? How do we achieve an honest perspective about what we really "know"? Two recent books, "Dreams of a Final Theory," by Steven Weinberg, and "The Astonishing Hypothesis: The Scientific Search for the Soul," by Francis Crick, take scientific thought uncomfortably close to previously metaphysical concepts of consciousness—the soul and God. These books reveal two scientists exploring realms Callahan might think best left to philosophers and theologians.

In "Dreams of a Final Theory," Nobel Prize-winning physicist Steven Weinberg, who described the Big Bang Theory in the book, "The First Three Minutes," writes about the quest for the ultimate explanation for physical phenomena, "the ancient search for those principles that cannot be explained in terms of deeper principles." This is called reductionism—the belief that scientific principles "can be traced to one simple connected set of laws." Starting with a piece of chalk as a focus of investigation, he keeps asking "why,"

leading us past chalk's whiteness, to calcium atoms, to quarks, and beyond. This is foreign territory to those of us whose formal education stopped at electron shells. Although he acknowledges that science currently has limits, Weinberg presses on as an unrepentant reductionist, looking for explanations for everything, even "historical accident." His penultimate chapter "What about God?" speculates about a world with the "final theory" understood (and quotes Stephen Hawking, who referred to the laws of nature as "the mind of God"). Weinberg predicts that the final laws of nature will accord "no special status for life and intelligence" and contain "no standards of value or morality." He reiterates his contention from "The First Three Minutes" that "the more the universe seems comprehensible, the more it seems pointless." Perhaps we will have purchased understanding at the price of fulfillment.

Another Nobel Prize winner, Francis Crick of DNA fame, examines consciousness in "The Astonishing Hypothesis." He takes us from neurons to neural networks to behavior using the neurophysiology of vision as his example. He pursues a reductionist "astonishing hypothesis" that: "You, your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behavior of a vast assembly of nerve cells and their associated molecules." When we understand all of these interactions, we will then understand consciousness, and perhaps the "soul," like we understand the behavior of a ball on an inclined plane. Crick speculates that all we see, all we know, all we feel will be explainable as a complex sequence of neuron interactions. His jump from known neurophysiology to a glimpse of the soul is even more extreme than Weinberg's stretch from quarks to God.

This is heady and uncomfortable stuff. God and the soul have long

seemed beyond the grasp of scientific logic, concepts with which we grapple with a different part of our brains. Which brings us back to Callahan. The drive to understand and control disease and death mirrors the hunt for the final theory of physics and the astonishing hypothesis. Do we relentlessly demand mastery and scientific understanding of our world and ourselves and recoil crestfallen when we inevitably fail? Or do we follow Callahan and seek an acceptance of our meekness and mortality? He rejects the notion that choice, "the control over life and death," is "the final meaning of human existence."

So what does Callahan offer instead? He shuns what he sees as the reductionists' vain search for ultimate answers, and he accepts "the notion that sense can be made of death as part of a biological life that

must come to an end." With this understanding, he tackles euthanasia, assisted suicide, and futile care and offers "peaceful death" guidelines. His analysis of these issues is thoughtful, provocative, and, I think, wise.

As he did in "Setting Limits," Daniel Callahan has eclipsed the public rhetoric on end-of-life issues and illuminated the pith of the problem. He tells us that neither living wills nor Quinlan cases will help us deal with death in the 21st century—neither will Crick's neurons or Weinberg's quarks. Instead, we need to look deep into our "soul" as we currently know it, and come to peace with death as a part of life. **MM**

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.

**Interested
in an
investment
program that
uses
no-load
mutual
funds?**



**ADVISORY
SERVICES**

One that also offers:

- *Professional management without commissions**
- *Asset allocation*
- *Consolidated reporting*

If this sounds like a better way to invest, call today and ask me about our SAM program.

Wayne E. Bernardo

2500 Foshay Tower
Minneapolis, MN 55402
(612) 337-8484
(800) 755-5877

*Investors in SAM pay a small annual fee based on account value; nominal transaction costs occur

LINSCD/PRIVATE LEDGER A REGISTERED INVESTMENT ADVISOR

GERVAIS

(continued from page 7)

with a substantial legacy, and the Minnesota center is well integrated with the active community of bioethicists here in the Twin Cities," she says, citing not only the Center for Biomedical Ethics, but also an "unusually large and collegial community" of experts from a variety of professions. "Now that we have two centers, we have places where these people can work together on a wider range of projects."

Gervais tells people not to waste too much ink laying out the differences between the University of Minnesota's Center for Biomedical Ethics, which began in 1985, and the Minnesota Center for Health Care Ethics. "There is so much important work to do that it's not like the Twin Cities couldn't support *more* than two centers," she says. If pushed, she'll tell you that her organization can be defined by its commitment to diversity and emerging issues in health care, and might be considered more clinically and institutionally focused than the academic- and research-oriented university center. "But I really think it's a mistake to say we're more this or they're more that," she adds. "We have mutual admiration, long-standing ties, and a very engaged connection."

Like many medical and bioethics professionals, Gervais is concerned about the future of the physician-patient relationship under managed care. She has called for the development of a managed care ethic and is trying locally to bring people in managed care together with ethics professionals to develop and disseminate this new ethic. It is, she says, a crucial component of what she, as the center director, hopes to achieve.

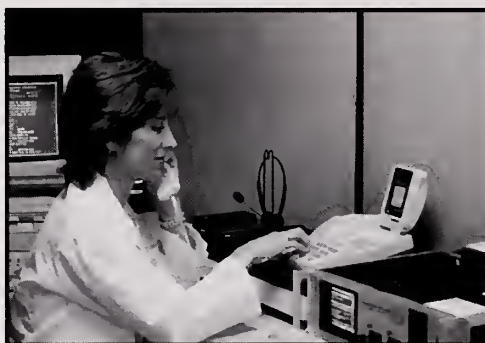
"[The physician-patient relationship] is an essential human relationship at the center of caring and healing," Gervais says. "I don't see how that can be replaced by a team." Making managed care work, she believes, will require combining two very distinct traditions: protecting the individual while at the same time

serving the goals of the community. Gervais' plans call for the Center for Health Care Ethics to be implicitly involved in creating a managed care ethic, which she says will be "the most substantive bioethics

achievement of this century since the articulation of the patient autonomy ethic." MM

Margaret Rog is a free-lance writer based in St. Louis Park, Minnesota.

Clinical Video Telemonitoring Keeps You Close To Your Patients



What You Can Expect From Us

Daily, or as-needed, routine & scheduled telemonitoring by trained nursing staff under the oversight of a physician, as well as emergency care response 24 hours a day, 7 days a week.

What Telemedicine Means For You

A new way to assist you in the care of your elderly, disabled, or post-operative patients, in their homes, by our trained nursing staff.

Systematic remote video assessment of your patients and their vital signs according to your orders.

Accurate instant information to you on your patient's clinical condition.

Customized and timely patient reports to your office.



What Telemedicine Means For Your Patient

Reduced costs compared to traditional long term care.

Full training on the easy to use video telemonitoring system.

Privacy, independence & security in the comfort of their own home.



For detailed brochure and additional information, call 612-897-0000. American TeleCare, Inc., 7680 Golden Triangle Dr., Eden Prairie, MN 55344-3732.

COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
 Bloomington, MN 55437
 Local (612) 881-0618
 WATS (800) 328-6246
 FAX (612) 881-7297



C. F.
anderson
 COMPANY, INC.

YOCON[®]

YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

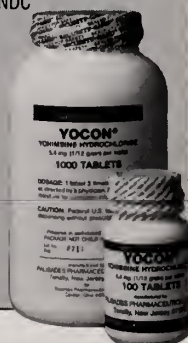
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



AVAILABLE AT
 PHARMACIES NATIONWIDE
PALISADES
PHARMACEUTICALS, INC.

64 North Summit Street
 Tenafly, New Jersey 07670
 (201)-569-8502
 1-800-237-9083

DI Coverage: Going, Going ...

Most physicians carry some sort of individual disability income insurance. From medical school on, doctors are approached time and again by agents and planners of all kinds, offering to review the coverage currently in force. The trend has always been one of better policy features and more and more aggressive marketing. In short, if one company wasn't willing to give the doctor the coverage he or she desired, there were literally dozens of other companies ready to fill the void.

End of an Era

But, those days are gone. In the last two months, the individual disability insurance industry has seen the withdrawal of one of the top four major carriers, UNUM, and other carriers have announced major changes to the types and costs of policies offered to physicians. Poor claims experience from these companies' 1985-1989 blocks of business, and especially poor claims experience with physicians in particular, has led these companies to take the actions stated above.

What Happened to DI?

In the simplest terms, overaggressive marketing and sloppy under-



Time is running out.

writing created a situation in which companies charged unrealistically low premiums and then had to pay more in claims than they had projected. Since the true financial performance of a disability product isn't known for several years, by the time some of these DI underwriters realized what was happening, it was too late to take corrective action. Compounding the problem in the physician marketplace was the fact that large numbers of doctors were underwritten by these companies, and doctors made large numbers of claims over the past 18 months.

So Now What?

The net result is that physicians today are no longer preferred business by all carriers. And, what

most doctors have now for individual disability income coverage is what they will have to stay with. There is, however, a very small window of time left for a review of that coverage, but within the next few months, the ability to purchase the same quality DI contracts most physicians enjoy today will not be possible. Among the items that some carriers have scheduled for the chopping block are fixed premiums, "own occupation" protection, and voluntary rehabilitation benefits.

All Is Not Lost

Not all companies are pulling out of the individual disability income arena. Among the few who will remain is the MPIA-endorsed carrier, Paul Revere. As the nation's leading disability carrier, Paul Revere is better situated to weather the current storm. Although experiencing some of the same difficulties as other carriers, it has managed to remain profitable while offering competitive DI products to physicians.

For further information, contact your MMA-owned Minnesota Physicians Insurance Agency at 612/623-2860 or toll-free 800/298-MMBR.

People and Places Making Medical News

People

Fairview Regional Vice President

Fairview Health System has named **Scott Wordelman** regional senior vice president. Wordelman will direct Fairview's health care activities in the regions served by Chisago Health Services (CHS) and District Memorial Hospital (DMH) of Forest Lake, which are both part of the Fairview Health System. He will be responsible for planning and construction of a new regional facility Fairview is building on Interstate 35, maintaining key medical staff and board relationships, and designing and implementing the regional organization. In addition to his new role, Wordelman will remain president and chief executive officer at CHS.

Fairview also named **Mark Lunseth** as chief financial officer for the new CHS/DMH region and Fairview Northland Regional Hospital in Princeton. He has been Chisago Health Services' vice president and chief financial officer.

Places

Mayo Unit Designated Level One Trauma Center

The Mayo Emergency/Trauma Unit at Saint Marys Hospital has been designated a Level One Trauma Center by the American College of Surgeons. It is the third emergency/trauma unit in Minnesota to achieve this designation and one of approximately 50 trauma centers nationwide. The American College of Surgeons describes a Level One Trauma Center as a "regional resource trauma center that provides leadership and total care for every aspect of injury, from prevention through rehabilitation." The designation is based in part on clinical capabilities and facilities

resources, along with devotion of resources and personnel to emergency medical patient care, education, and research.

U Kids Undergoing \$1.2 Million Renovation

The University-Variety Hospital for Children (U Kids) will embark on a \$1.2 million renovation that will consolidate, redecorate, and improve pediatric patient and family care areas. Three separate units will be combined into a 54-bed general care unit featuring separate playrooms for younger and older children, a hospital school, a teen lounge, a family kitchen with washer and dryer, a parent lounge/library with sleeping accommodations, and a private consulting room.

St. Paul Blood Services Changes Its Name

After 46 years, the St. Paul Blood Services Region of the American Red Cross has changed its name to North Central Blood Services to better reflect its vast geographic reach. The center collects blood throughout much of Minnesota, Wisconsin, Iowa, South Dakota, and North Dakota and provides blood components to 145 hospitals in those states. "We are the largest blood-providing organization in the north-central part of the United States, and indeed, one of the largest in the country," said Robert Bowman, M.D., principal officer at the center.

Mayo Clinic Physician Honored by \$1 Million Gift

Edward and Betty Scripps, owners of the Scripps League Newspapers, have given a \$1 million gift to the Mayo Foundation to honor their physician, **Edward C. Rosenow III**, M.D., a specialist in thoracic medicine at Mayo Clinic. The Mayo Foundation will use the

money to endow the **Edward W. and Betty Knight Scripps Professorship of Medicine in Honor of Dr. Edward C. Rosenow III** at Mayo Medical School.

The Scripps said in a *St. Paul Pioneer Press* article that they consider Rosenow "a fine example of one of the most dedicated physicians in the country."

Gillette Announces Children's Pain Program

Gillette Children's Hospital in St. Paul has opened a chronic pain program for adolescents and children. The program is the first in a five-state region to focus solely on children and adolescents, who need different treatment for chronic pain than adults. The main goal of the program is to enable children and adolescents experiencing debilitating pain to participate fully in school and at home and to prevent the pain from interfering with social skills development. The program works in conjunction with a variety of hospital experts, including doctors, therapists, psychologists, social workers, and various other specialists.

Socioeconomics

MDH Receives Grant to Track Infectious Diseases

The Minnesota Department of Health has been awarded a \$350,000 grant from the Centers for Disease Control and Prevention to set up a system to detect emerging diseases, such as the next AIDS or hanta virus, and track infectious disease outbreaks. Minnesota is one of four states selected to participate in the CDC's emergency infections program network. The other states are California, Connecticut, and Oregon.

State epidemiologist **Michael Osterholm** said every hospital and

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Pediatrics
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



dozens of physicians and other health care providers will send blood, tissue, and stool samples from people with mysterious fatal and severe illnesses to the MDH laboratory, which will test for causes. The department will initiate three projects. In the first, it will monitor the incidence of invasive bacterial infections and attempt to come up with ways to control and prevent outbreaks. The second project will investigate mysterious infection-related deaths and serious illnesses. The third project will use molecular fingerprinting of bacteria to detect outbreaks of food-borne or water-borne illnesses caused by *Salmonella*, *Shigella*, *Campylobacter*, and *E. coli*.

New Pioneer Licensed as CISN

New Pioneer Health Plan, based in Willmar, Minnesota, has received licensure from the Minnesota Department of Health to operate as a Community Integrated Service Network (CISN). The plan is a partnership between Affiliated

Medical Centers and Blue Cross and Blue Shield of Minnesota.

New Pioneer began operation on January 1 and will begin enrolling members as of March 1. It will initially offer a health plan for small and medium-sized employers in a 15-county service area. The CISN includes about 125 primary care physicians, which is about 93 percent of all primary care physicians in the 15-county area. All 23 hospitals in the area are contracted providers.

Fairview Reorganizing

Fairview Health System is conducting a reorganization to eliminate a projected \$18 million budget shortfall for 1995. Changes include the departure of two senior executives, Donald Ramsey, chief financial officer, and Douglas Robinson, senior vice president of operating systems and capacity planning. They will leave the company in about six months.

No large-scale layoffs are planned, according to Fairview President and Chief Executive Officer Richard Norling. "Our target of \$18 million is about 3.8 percent of our total expense base," he said in a *CityBusiness* article. "We've spent well in excess of \$1 million in re-engineering teams and quality improvement teams over the last year or two, and we fully expect those teams to generate the vast majority of reductions." He said some reductions will come from redesigned work and more integrated relationships with key vendors. Although he doesn't expect large-scale layoffs, he said there could be "displacement" as people are moved from unprofitable areas to fast-growing ones.

HealthEast's Finances Looking Better

HealthEast's net income for fiscal year 1994 was only slightly lower than in 1993, a trend that analysts considered positive considering the closings and layoffs the hospital system experienced in the past

year. Net income dropped \$1.2 million, or 17 percent, to \$5.8 million for the year ending August 31. A large part of the drop was due to \$1.5 million in restructuring expenses, largely severance and early retirement costs, said Roger Green, HealthEast spokesperson. Operating revenues were up \$10 million, to \$307 million. Total cash and short-term investments were up \$7 million, to \$55.5 million. Total current assets were up \$9 million, to \$109 million.

In March, HealthEast closed acute care services at Divine Redeemer Hospital, and the hospital system laid off 275 full-time-equivalent employees—7 percent of its total work force.

HealthEast Acquires Two Clinics

HealthEast has acquired two new clinics, East Side Medical Center with offices in St. Paul and Oakdale, and Family Practitioners located in Cottage Grove. Each clinic has eight family physicians. According to a HealthEast news release, the agreements will not affect any present relationships or contracts with insurers or health maintenance organizations. HealthEast currently owns 18 clinics.

Rates, Trends, Data

Infant Mortality Up in Minnesota

Minnesota's infant mortality rate increased from 7.1 per 1,000 live births in 1992 to 7.5 in 1993 because of a large increase in the number of white infant deaths—415 in 1993, up from 368 in 1992. The mortality rate for white infants increased from 6.4 per 1,000 live births in 1992 to 7.3 in 1993, according to a report from the Minnesota Department of Health's Center for Health Statistics.

Meanwhile, the mortality rate for African-American infants dropped from 14.5 per 1,000 live births in 1992 to 11.1 in 1993. The rate decreased dramatically for American Indian infants—from 18.9 in 1992 to 8.7 in 1993. The death rate for Asian infants in-

creased slightly, from 6.7 in 1992 to 6.8 in 1993.

The report also showed that the state's overall birthrate dropped from 14.7 per 1,000 residents in 1992 to 14.3 in 1993. The out-of-wedlock birthrate increased from 22.9 per 1,000 residents in 1992 to 23.3 in 1993.

According to the report, heart disease is the state's leading killer, followed by cancer, strokes, and violent deaths. The number of violent deaths increased by 1.3 percent, from 2,163 in 1992 to 2,191 in 1993.

Percentage of Uninsured Hospital Patients Up

The percentage of hospital patients in the Twin Cities who have no insurance has increased in recent years, according to a study by the Metropolitan Health Care Council. The study, which examined data from patients under age 65 from 25 metro-area hospitals, found that overall hospitalization rates decreased between 1989 and 1993 (from 99.4 per 1,000 people to 88.3 per 1,000 people), but the hospitalization rate for uninsured patients increased slightly, from 3.3 to 3.6 per 1,000 people.

The report suggested that this could be because uninsured people are sicker when they reach the hospital than those with health coverage. According to a Minnesota Health Care Commission study, 28 percent of uninsured people say they delay care because they have no coverage; of those, 70 percent say they delay care for a serious health problem.

The cost for Twin Cities hospitals to care for the uninsured increased from \$18.9 million in 1992 to \$20.4 million in 1993—an increase of 7 percent.

Innovations

New Infertility Treatment Promising

The Mayo Clinic recently reported promising results using a new fertility technique in which sperm are directly injected into eggs and

then transferred to the uterus. Of 40 couples treated with the technique, 39 had embryos to transfer. The current ongoing pregnancy rate is 48 percent. "This is the most exciting development in the fertility field since in vitro fertilization,"

said Diane Hammitt, Ph.D., a Mayo embryologist and director of Mayo's In Vitro Fertilization and Fertility Testing Laboratories. Patients with low sperm counts, low sperm movement, abnormal sperm function, or congenital

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

612-885-6224

1-800-842-6469



absence of the vas deferens are good candidates for the procedure, which is called intracytoplasmic sperm injection.

Medical Research

Family History of Prostate Cancer Increases Breast Cancer Risk

University of Minnesota researchers report that women whose fathers or brothers have had prostate cancer have a 19 percent greater than average chance of developing breast cancer, even when they have no other family history of breast cancer. The study, which included more than 30,000 post-menopausal Iowa women, was published in the December 21 *Journal of the National Cancer Institute*. Women with breast and prostate cancer in their immediate families have more than double the average risk of developing breast cancer after menopause; women with a family history of breast cancer, but no history of prostate cancer, had a 37 percent increased risk of developing breast cancer.

Pain Assessment Tool Aids Caregivers

A Mayo Clinic study shows that daily use of a verbal pain assessment tool appears to significantly improve caregivers' understanding of pain experienced by cancer patients. This method, which rates pain levels, is expected to enhance communication between the caregiver and the cancer patient. The study, published in the December *Journal of Clinical Oncology*, showed that caregivers frequently underestimated patients' pain intensity. Further research will help physicians determine whether this increased awareness will improve drug administration practices and patients' outcomes.

AIDS Update

Women With AIDS Have Worse Survival Rate Than Men

Women with HIV die more quickly than men with HIV, even though

the disease progresses at the same rate, according to a study published in the December 28 *Journal of the American Medical Association*. The researchers, led by epidemiologist Sandra Melnick of the University of Minnesota (now with the National Institute of Allergy and Infectious Diseases in Bethesda, Maryland), found no apparent medical reason for the difference. They said women may wait longer to seek care or they may be treated differently.

The study followed 768 women and 3,779 men enrolled at 17 community-based centers between September 1990 and September 1993. Patients were followed for a median of 15 months. The study found that women were about 30 percent more likely to die suddenly, apparently without first developing infections and cancer associated with HIV.

AIDS Deaths on the Rise

AIDS deaths in Minnesota hit an all-time high in 1994, with additional deaths still being reported. At the close of 1994, Minnesota Department of Health officials knew of at least 234 AIDS deaths in the state, and late reports are likely to increase the total to about 250—the first year the number will be above 200.

New HIV Saliva Test

The U.S. Food and Drug Administration approved a new AIDS virus test in December. By using saliva instead of blood, the test is intended to encourage those who avoid blood tests but are at risk for HIV to be tested for the virus. The test will be available only from physicians and administered only by those specially trained in its use.

The test will look for antibodies to the virus, not the HIV virus itself, which hasn't been located in saliva. A positive result from the saliva test will be followed by a specific blood test. The FDA said that in clinical trials the new test showed a 2 percent error factor in both positive and negative results.

MM

Unique Surgical Opportunity

Estherville, Iowa (population 7,500) is seeking a General Surgeon. Northwest Iowa location in the Lakes Region with outstanding outdoor recreation. Six referring family practice physicians. Minimal Managed Care. For more information contact:

Tom Nordwick, CEO
Holy Family Hospital
826 North 8th Street
Estherville, IA 51334-1598
712-362-2631



HOLY FAMILY HOSPITAL
A MEMBER OF THE MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

MINNESOTA LICENSED LOCUM TENENS PHYSICIANS AVAILABLE!

For hassle-free help to cover for vacations or absences from your practice, call today. All major specialties covered.

Medical review officers now on staff.



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.

Eight First Ave. S.
Buffalo, MN 55313

Phone: 800/876-7171

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

FEBRUARY 1995

Feb. 8-12 **Neuro-imaging at Turnberry Isle** University of Minnesota Continuing Medical Education; Turnberry Isle, Aventura, FL. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Feb. 9-11 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 10 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 15-19 **Pain Management Conference** MeritCare; Big Mountain, Whitefish, MT. CONTACT: Sue Heinze, 720 Fourth Street North, Fargo, ND 58008; 701/234-5737.

Feb. 20-24 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Feb. 24 **Through the Eyes of Others: Is Health Care Culturally Competent?** Hennepin County Medical Center; Earle Brown Continuing Education Center, St. Paul Campus, St. Paul, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829, 612/347-2078; or Robin Hoppenrath, 612/337-7128.

Feb. 25 **Issues In Pediatrics** MeritCare Children's Hospital; Holiday Inn, Fargo, MN. CONTACT: Sue Heinze, MeritCare Children's Hospital, 720 Fourth Street North, Fargo, ND 58122; 701/234-5737.

MARCH 1995

Mar. 6-10 **Medical Update 1995** University of Minnesota Continuing Medical Education; Holy Cross Hospital, Fort Lauderdale, FL. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107,

Minneapolis, MN 55414; 612/626-7600.

Mar. 9 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-10 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

FEBRUARY 1995

Feb. 28 **Pediatric Infectious Disease Update** St. Joseph's Medical Center; St. Joseph's Medical Center, Brainerd, MN. CONTACT: S.J. Bode, Resource Coordinator, 523 North Third Street, Brainerd, MN 56401-3098; 218/828-7414.

MARCH 1995

Mar. 11 **Infectious Diseases** Group Health Foundation; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Debbie Beadine, 8100 30th Avenue South, Bloomington, MN 55425; 612/883-5341.

Mar. 24 **The Primary Care of HIV 1995** Allina; Holiday Inn International, Bloomington, MN. CONTACT: Don Young, Allina, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

APRIL 1995

Apr. 12 **Infectious Disease Update/TB/Hepatitis/HIV** St. Joseph's Medical Center; St. Joseph's Medical Center, Brainerd, MN. CONTACT: S.J. Bode, Resource Coordinator, 523 North Third Street, Brainerd, MN 56401-3098; 218/828-7414.

MAY 1995

May 5-6 **Common Infections of Mothers and Infants—Prevention and Management** Children's Health Care, Minneapolis/St. Paul; St. James Hotel, Red Wing, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-5884.

Mar. 13-17 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

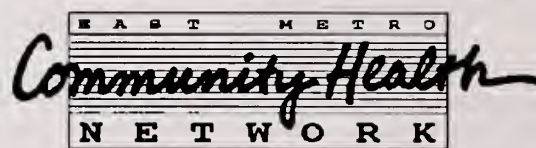
Mar. 17 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 19-24 **Brain to Pelvis** University of Minnesota Continuing Medical Education; Beaver Creek Resort, Avon, CO. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Mar. 24 **Eleventh Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Mar. 24-26 **Advances in Clinical Anesthesiology** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 27-31 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.



**Nurse
Practitioner**

The East Metro Community Health Network has full and part-time openings for a Nurse Practitioner in Adult or Family Medicine. The ideal candidate will have an interest in working with low-income/minority populations. Must be a graduate of an accredited program and licensed to practice in Minnesota. Attractive hours, salary, benefits. Interested applicants send resume to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

Internal Medicine/Family Practice Spring Lake Park Medical Center

Become a member of Group Health, Inc. physician staff at our Spring Lake Park Medical Center. We have positions available for full time board certified/board eligible Internal Medicine/Family Practice physicians.

With a personable staff of primary care physicians, this clinic offers a solid patient base and reasonable call and hospital responsibilities.

Group Health, Inc., a progressive, managed care organization since 1957, is one of the largest multispecialty group practices in the Midwest. Group Health offers its physicians a balanced life-style, excellent salaries and a generous benefit package that includes paid malpractice.

If you are interested in starting a practice at the Spring Lake Medical Center, please call Ann Mliner, at (612)883-5337, 1-800-472-4695 or send CV to: Group Health, Inc. A division of HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

Group Health is part of the HealthPartners family of health plans. An EO/AA Employer.



HealthPartners

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., February 15 for April ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Family Physicians, P.A., 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician, multispecialty practice located just south of the Twin Cities

on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/835-3609, or send inquiries to 7801 East Bush Lake Road, Suite 400, Bloomington, MN 55439. (*3/93-R)



Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)

*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, Medicare and CAC.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aids, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 20 physician multi-specialty Group currently recruiting additional physicians in the following specialties:

- GENERAL SURGERY
- INTERNAL MEDICINE
- OBSTETRICS & GYNECOLOGY
- FAMILY PRACTICE
- PEDIATRICS

First year salary guarantee with production bonus, second year partnership. Excellent contract benefits.

If Interested In joining a young, growing organization located in beautiful lakes area community, please contact:

Timothy A. Hunt, Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/ Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Donald Weinshenker, M.D.
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Family Practice/General Surgeon, BC/BE, to join progressive 25-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Hwy. 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. *3-2/95

Primary Care Physicians and Subspecialists are being sought for a variety of group practices located throughout the upper Midwest and New York state. Choose from metropolitan cities, college towns, popular resort communities, or traditional rural destinations. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology, and nephrology. New opportunities monthly! For all of the facts, call 800/243-4353, or write to: Strelcheck and Associates, 10624 North Port Washington Road, Mequon, WI 53092. *3-4/95

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-5237 MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.

Urgent Care

Additional full-time BC primary care physician needed to join our UrgentCare Clinic for expanding hours of service. Join our collegial team of physicians and support staff in a position offering a competitive salary and comprehensive benefits. Weekday and weekend schedules.

For more information, contact:

Linda Basara, Director
Physician Placement
St. Luke's Hospital
915 East First Street • Duluth, MN 55805
1-800-321-3790
(218) 726-5356

St. Luke's
MEDICAL CLINIC

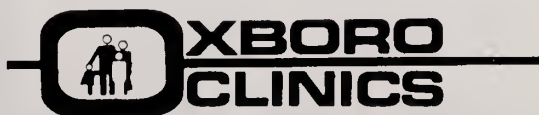
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469



Columbia Park Medical Group

- OB/GYN ● BC/BE Specialists
- Family Practice ● Internal Medicine

OB/GYN:

Three BC Physicians are looking for a fourth to join in their busy practice.

FAMILY PRACTICE: Join Group or do Locum Tenens

Join 25 member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE:

Six member Department has busy hospital and clinic practice.

Columbia Park Medical Group is a physician owned multi-specialty group. The 60 physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered.

Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Tom Behrend
(612) 586-5882

No Assembly Lines Here: FPs, IMs, and ob/gyns at North Memorial-owned and -affiliated clinics don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of our 25 practices in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE M.D.s call 800/275-4790 or fax CV to 612/520-1564. *1-2/95

Family Practice, Minneapolis: BC/BE family practice physicians needed to join the family practice department of a 385-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Shakopee and Prior Lake offices. Salary and benefits are highly competitive. For additional information, contact Patrick Moylan at 612/993-3286, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; Fax: 612/993-2819. *2-3/95

Mork Clinic, P.A.—Anoka, Minnesota: BC/BE obstetrician/gynecologist needed to join growing physician-owned, primary care, multispecialty, seven-physician clinic. Two well-equipped offices in Anoka and Elk River. Utilization of one hospital. Excellent professional opportunity with ample time to enjoy family life. Contact Curt Keller, M.D., Mork Clinic, P.A., 1833 Second Avenue South, Anoka, MN 55303. *3-3/95

Your Future is Our Future

Join the newest member of the Fairview family - Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, our organization has joined the Fairview Health System.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

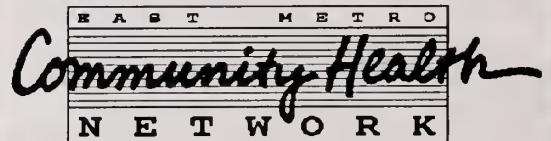
Our 22 member medical staff has openings in the areas of:

Family Practice	OB/GYN
Internal Medicine	Urgent Care

CHISAGO HEALTH SERVICES



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469



Physician Family Medicine

The East Metro Community Health Network is seeking a BC/BE family medicine physician with an interest in community-based health care. The ideal candidate will have an interest in working with low-income/minority populations. Must be licensed to practice in Minnesota. Attractive hours, salary, benefits. No call. Full and part-time positions available. Interested applicants send CVs to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *3-3/95

BC Family Physician to join high-quality, 17-M.D., single-specialty family practice group. Four sites in the Minneapolis northwest metro area. Very reasonable lifestyle with competitive salary and benefits. Contact Jamie Peters, M.D., Northwest Family Physicians, 1495 State Highway 101 North, Plymouth, MN 55447; 612/476-6776. *3-3/95

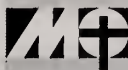
Internal Medicine—Carroll, Iowa: Outstanding opportunity for an internal medicine physician in a progressive, safe, and clean community of 10,000 located in west-central Iowa, 90 miles from Des Moines, Iowa, or Omaha, Nebraska. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 square-foot outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, St. Anthony Regional Hospital, 800/382-4197. *6-4/95



You'll be glad you found Monroe

Our safe, family-centered community of 10,000 is just one hour from Madison, WI, Dubuque, IA and Rockford, IL...two hours from Chicago and Milwaukee...and number 23 in *100 Best Small Towns in America*. But the 50+ physicians in our multispecialty group practice rank Monroe number one. That's because of the town's friendly spirit, four-season climate, abundant recreational, educational and cultural amenities, relaxed pace, and the exciting professional opportunities at The Monroe Clinic—a consolidated, integrated healthcare facility including a new 114,000 sq. ft. clinic and an adjoining 140-bed acute care hospital with 24-hour ER coverage serving south central WI and northern IL. We have openings for BC/BE physicians in: FAMILY PRACTICE, OB/GYN, CARDIOLOGY (non-invasive), OUTPATIENT PSYCHIATRY, GENERAL SURGERY, ORTHOPEDIC SURGERY, PULMONOLOGY, AND DERMATOLOGY.

We offer productivity based pay with excellent 1st year income guarantee, freedom from office management and buy-in costs, and comprehensive benefits including \$3750 CME allowance. For more information, write or call: Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. 800-373-2564. Or fax resume to: 608/328-8269. EOE.



The Monroe Clinic
A proud caring tradition

Just for a Moment Imagine...

...what you want life and practice to be.



Aberdeen is a major regional medical center, with a modern 225-bed hospital and over 70 practicing physicians. Serving northeast South Dakota and southeast North Dakota. A community with concern for your needs and respect for your privacy.

Opportunities available:

- Family Practice • Orthopedic Surgery
- Pediatrics • Urology
- Nephrology

Aberdeen... Life & Practice, Just As You Imagined.

St. Luke's Midland
Regional Medical Center



Contact: Bebe Janish
305 S. State Street • Aberdeen, S.D. 57401
605-622-5874

OUR HIGH GROWTH LOCALE Means Expanding Opportunity

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

St. Croix Falls Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detail CV to:

Cathy Kortas
River Valley Medical Center
208 S. Adams Street
St. Croix Falls, WI 54024
(715) 483-3221

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

*University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System*

Escanaba, Michigan

*Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living*

BC/BE Physicians Needed

<i>Family Practice</i>	<i>Pediatrics</i>
<i>Internal Medicine</i>	<i>Neurology</i>
<i>Orthopedic Surgery</i>	<i>OB/GYN</i>
<i>Gastroenterology</i>	<i>Urology</i>
<i>Noninvasive Cardiology</i>	

Send your CV to Gary Luiten, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/862-9012.

FEBRUARY 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
American Telecare Inc.	50
Army Reserve	42
Aspen Medical Group	32
Blue Cross and Blue Shield of Minnesota	2, 3
C.F. Anderson Co., Inc.	47, 51
Central Minnesota Group Health Plan	47
Chisago Health Services	62
Columbia Park Medical Group	62
Comprehensive Medical Care	63
East Metro Community Health Network	58, 62
Fairview Clinic Services	55
Fargo Clinic MeritCare	23
HealthPartners	42, 58
Hennepin Faculty Associates	Cover 3
Holy Family Hospital	56
Leonard, Street & Deinard	16
LPL Financial Services	49
Mankato State University	61
Minneapolis Otolaryngology	47
Minnesota Medical Business Resources	41
Minnesota Physicians Insurance Agency ...	Covers 2 & 4, 32, 52
Monroe Clinic	63
Moonlight Home Health Care	60
Multicare Associates of the Twin Cities	54
Oxboro Clinics	61
Palisades	51
River Valley Medical Center	64
St. Francis, Inc.	64
St. Luke's Hospital	61
St. Luke's Midland Regional Medical Center	63
St. Paul-Ramsey CME	23
Veterans Administration Medical Center	60
Webb Financial Group	17
Whitesell Medical Locums, Ltd.	56

Hennepin County Medical Center Hennepin Faculty Associates **CME ACTIVITIES**

Sponsored by the University of Minnesota and Hennepin County Medical Center.
Programs are designed for physicians' continuing education credit and other specialty education credit.



Through The Eyes of Others: Is Health Care Culturally Competent?

Primary Audience:

Primary care physicians, Allied health care providers

February 24, 1995

Earle Brown Continuing Education Center, St. Paul Campus

Chair: Marvin Brooks, MD, Douglas Drive Physicians

This program will focus on cultural competence and sensitivity and its impact on patient outcomes.

Keynote: Lonnie Bristow, MD, President-Elect, American Medical Association • 6.5 Credits

HIV
PRIMARY CARE
CONFERENCE



MARCH 1995

HIV Primary Care Conference

Primary Audience:

Primary Care Physicians, Allied health care providers

March 24, 1995

Holiday Inn International, Bloomington

Chair: Hanan Rosenstein, MD, Abbot Northwestern Hospital

This conference is designed to address management and medication issues of your patients with HIV • 7.0 Credits

Annual John I. Coe Symposium • March 31, 1995

Held in conjunction with the Annual MSP Meeting on April 1, 1995.

Primary Audience: Pathologists and Clinicians • Hennepin County Medical Center, Minneapolis

Program Co-Chairs: Fred Apple, PhD, HCMC -James Hernandez, MD, St. Cloud Hospital

The program this year will focus on thyroid testing • Approximately 6.0 credits

Phonosurgery: Indications and Techniques • May 19-20, 1995

Hands-on workshops on June 3rd limited to 24 physician participants.

Primary Audience: Otolaryngologists and Speech Pathologists • Hennepin County Medical Center, Minneapolis

Program Chair: George Goding, MD, HCMC • Approximately 16.0 credits

Advanced Life Support in Obstetrics (ALSO) • August 18-19, 1995

Primary Audience: Primary care physicians • Mall of America Grand Hotel, Bloomington • Program Chair: Vicki Short, MD, HCMC

This program is designed to assist health professionals in developing and maintaining the knowledge and skills they will need to effectively manage the emergencies that arise in Obstetrics. • Approximately 14.0 credits

For registration/brochure/or more information:

Ann Samways or Robin Hoppenrath

HCMC Office of Academic Affairs • 701 Park Ave., Mail Code 869-A • Minneapolis, MN 55415 • (612) 347-2075, FAX (612) 347-2154

KEEP YOUR RETIREMENT TO YOURSELF.

If there's anything in life that's worth waiting for, it's your retirement. Today, the Minnesota Physicians Insurance Agency (MPIA) can make sure your hard-earned income reaches its maximum growth and protection during those precious golden years of your life.

Here's how.

A non-qualified **PRIVATE PENSION** Plan—using life insurance from Northwestern National Life—will help you keep more for yourself. It offers many advantages over qualified plans like 401(k)s, pension and profit sharing. With Private Pension, you'll enjoy:

- Tax-deferred growth
- Tax-free income*
- Unlimited and flexible premium contribution
- No IRS penalty for early distributions
- No distribution requirements
- Will not affect Social Security benefits
- You have complete control
- Income-tax free life insurance death benefit

To find out more about **PRIVATE PENSION**, send the attached card to MPIA today, or call 1-800-999-1875. Because it's about time you **keep your retirement to yourself**.

Offered through:

MINNESOTA PHYSICIANS INSURANCE AGENCY

3433 Broadway St. NE, Suite 375, Minneapolis, MN 55413 612/623-2860

Representing:



**Northwestern
National Life**

* Tax-free income is provided by withdrawing funds you've contributed, then taking additional funds through policy loans. Under current law, policy loans are income-tax free provided the policy remains in force and is not a modified endowment, as defined in IRC §7702A.

Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

House hears
AMA reform bill, pg. 3

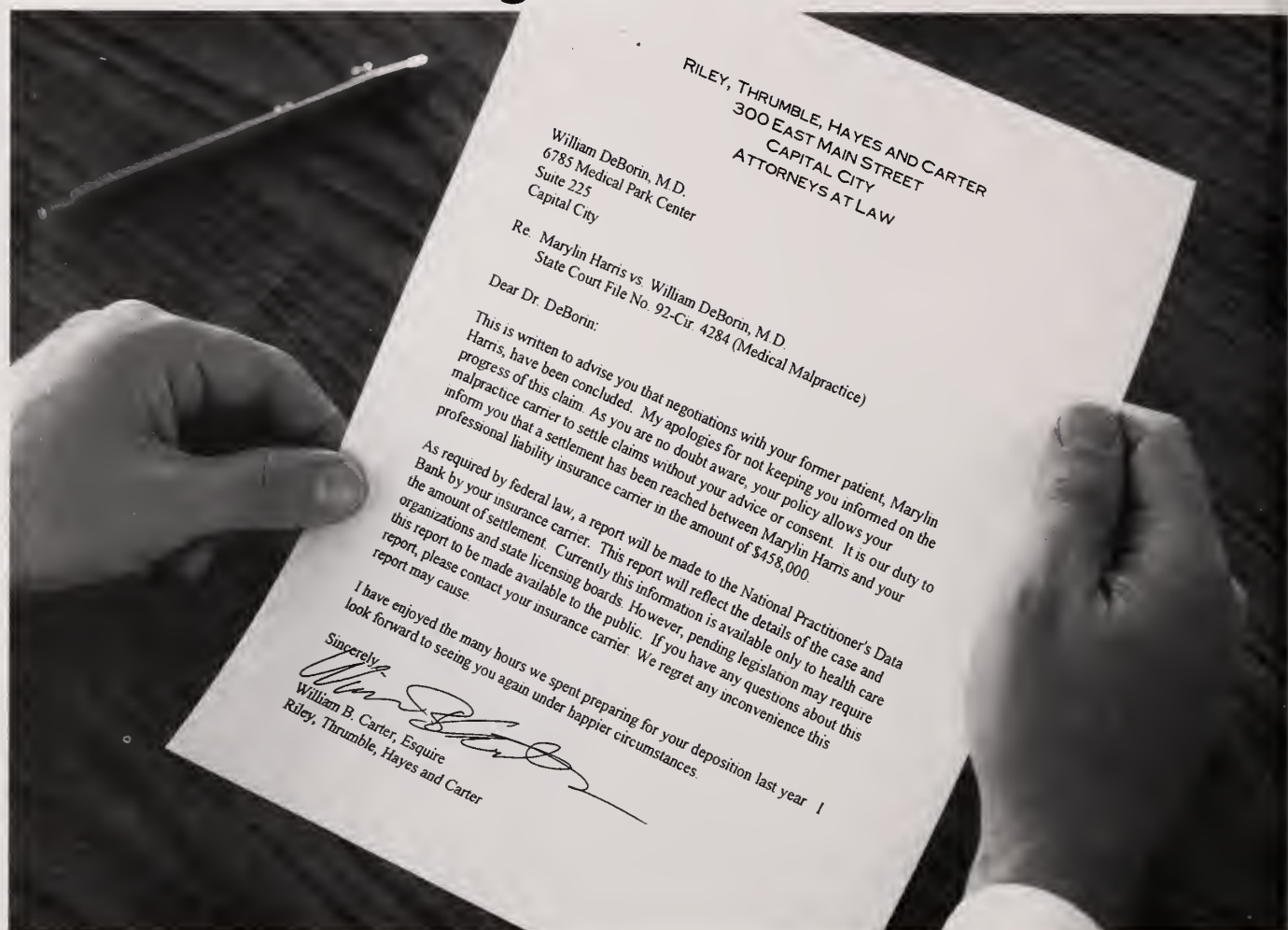


12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession, PA 15261-0001
Pittsburgh, PA 15261-0001

. Tuned-in to
Telemedicine . . .

MARCH 1995

Medical Protective Policyowners NEVER get letters like this!



RILEY, THRUMBLE, HAYES AND CARTER
300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marilyn Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

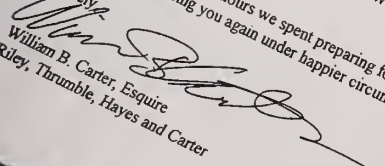
Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marilyn Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marilyn Harris and your professional liability insurance carrier in the amount of \$458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,


William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

THE
MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's

800/344-1899



MAR 15 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Image by Micheal Simpson, FPG International.

DEPARTMENTS

- 2 LETTERS TO THE EDITOR
- 5 EDITOR'S NOTEBOOK
- 50 NEWS CLIPS
- 56 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

6 MAYO DOC INSPIRES MULTI-CULTURAL

CARE Rebecca C. Gonzalez-Campoy
For family physician Walt Franz, the future of medicine is here and now—treating underserved patients and expanding students' horizons.

PERSPECTIVES

8 LOST TO FOLLOW-UP: A DETECTIVE STORY P. Michael Nordberg
Join professional tracer Michael Nordberg as he dons his Sherlock Holmes cap in a worldwide search for a study patient lost to follow-up.

FEATURE STORY

10 TUNED-IN TO TELEMEDICINE Robert Carlson
The technology that brings us e-mail and interactive video also delivers health care.

CLINICAL AND HEALTH AFFAIRS

19 RURAL MINNESOTA FAMILY PHYSICIANS' ATTITUDES

TOWARD TELEMEDICINE Jon Kane, Jeff Morken, Jim Boulger, Ph.D., Byron Crouse, M.D., and Dale Bergeron

25 HEALTH CARE FOR THE UNINSURED IN DULUTH Barbara Elliott, Ph.D., Colleen Renier, Laura Vecchi, and Terrence C. Clark, M.D.

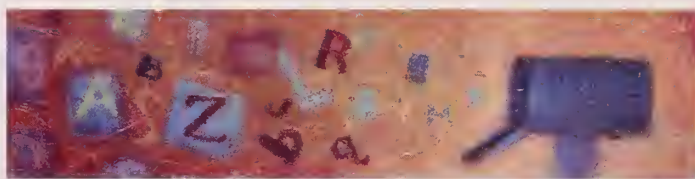
HEALTH REFORM SERIES

42 UNIVERSAL COVERAGE: POLICY OPTIONS AND

THE MINNESOTA EXPERIENCE Janet Silversmith
Minnesota has enacted legislation calling for universal health care coverage. The policy options for achieving this goal are numerous, as are the challenges.

33 *The* Monitor

HIGHLIGHTS House hears MMA's Quality & Coverage bill
• Opposition to RAPO builds • MMA will introduce Board of Medical Practice bill



Let's Not Forget Outstate Resources for Alzheimer's

I read with great interest the article "Dementia and Alzheimer's Disease: Indications, Diagnosis, and Treatment," by Richard Golden, M.D., in the January 1995 *Minnesota Medicine* (page 25). I was pleased to see the attention drawn to Alzheimer's disease in Minnesota. However, Dr. Golden's article focused on resources and research in the Twin Cities area only; I would like to inform *Minnesota Medicine* readers of other sources of Alzheimer's information and research throughout Minnesota.

The Mayo Clinic in Rochester has one of the nation's 28 Alzheimer's Disease Centers supported by the National Institutes of Health; it serves as a source for patient evaluations, education, and research in Minnesota and the Upper Midwest. Mayo is conducting several research projects on epidemiology, diagnostic techniques involving neuropsychology and neuro-imaging, neuropathology, and the treatment of Alzheimer's disease. Investigational

drug trials that are currently underway or will be initiating enrollment soon at Mayo include the study of nimodipine and acetyl-L-carnitine. More information regarding enrollment can be obtained by contacting Linda Linbo, R.N., 507/284-4006. For additional information about services provided by the Mayo Alzheimer's Disease Center, call 507/284-1324.

The Minneapolis Veterans Administration Medical Center also is conducting a drug study not cited in the January article. Under the direction of Maurice Dysken, M.D., VAMC is studying the compound SB202026. For more information regarding enrollment, contact Susan Anton-Johnson, R.Ph., 612/725-2000, Ext. 3334.

In the Duluth area, resources for the care of Alzheimer's patients are available through the Human Development Center under the direction of Peter Miller, M.D., who can be contacted at 218/728-4491. The Duluth Clinic also provides information and care for patients with Alzheimer's disease; the Department of Neurology can

be contacted at 218/722-8364.

Finally, the Alzheimer's Association, Minneapolis-St. Paul Chapter, is very active in supporting Alzheimer's patients and their families and is a valuable source of information. The Minneapolis-St. Paul Chapter can be contacted at 612/888-7653. In addition, there are local chapters and support groups throughout Minnesota.

Ronald C. Petersen, Ph.D., M.D.

Director

Mayo Alzheimer's Disease Center

Associate Professor of Neurology

Mayo Medical School

Rochester, Minnesota

Is Prozac Really Perilous?

"The Perils of Prozac" by Deane C. Manolis, M.D., (January 1995, page 19) is generally an excellent article, but it includes a few interesting contradictions. The article says that Dr. Steven Miles, a geriatrician and medical ethicist at the University of Minnesota and Hennepin County Medical Center, believes there is potential for primary care physicians to overprescribe Prozac. Dr. Manolis also tells us that awareness and recognition of depression are crucial first steps in treating depression and that underrecognition and undertreatment cost tens of billions of dollars. Depression is more common than hypertension in primary care. Major depression has a lifetime mortality of 15 percent.

So, we have a common, often lethal disorder that "may be overtreated" by primary care physicians but that is still undertreated. Given the safety of Prozac, shouldn't we welcome some tendency toward overtreatment?

As a family practitioner, I see



In the January 1995 issue, page 16, *Minnesota Medicine* neglected to credit the illustration at left to Tom Lochray, a Minneapolis-based free-lance illustrator.

many depressed patients—and recognize them. I have trouble convincing them that they are truly depressed and need treatment. I blame the ongoing stigma of mental illness for this phenomenon. Given this bias, I'm not sure how providing better access to mental health care would guarantee better treatment of depression. It would be more efficient to find ways to enhance primary care physicians' ability to diagnose, treat, and persuade patients to accept psychiatric intervention. The simplest way to achieve this would be a public awareness campaign to identify the signs and symptoms of depression and to sell the notion that primary care physicians are qualified and capable of diagnosing and treating depression. Prozac makes this job easier for us.

David A. Lang, M.D.
Family Practice Physician
Apple Valley Medical Center
Apple Valley, Minnesota

Dr. Manolis Responds

In "The Perils of Prozac," my intent was to indicate that some critics suggest there is a problem with overprescribing medications such as Prozac, and that physicians may be tempted to prescribe on patient demand or to prescribe for conditions that might better respond to counseling or psychotherapy.

I fully agree that public education is critical if we are to identify and treat major depression more appropriately. A number of national organizations have launched campaigns in recent years to educate the public, but unfortunately, information about mental illness is not sensational enough to get attention in the print or elec-

tronic media. The American Psychiatric Association has an ongoing campaign against the stigma of mental disorders and over the past several years has had a campaign entitled "Let's Talk" about mental illness. The National Mental Health Association has an educational campaign for Mental Health Month every May. The American Psychiatric Association and the National Alliance for the Mentally Ill jointly sponsor Mental Illness Awareness Week every October. For the past four years, one day of that week has been designated National Depression Screening Day. This has been a very active program, and the Minnesota Psychiatric Society has

sponsored many screening sites around Minnesota. MPS would be delighted to have the Minnesota Academy of Family Physicians co-sponsor National Depression Screening Day next October.

Personally, I have found that patients respond well to short pamphlets that describe depression in lay terms. A number of drug companies distribute these, and they are reasonably generic. Primary care physicians should find pamphlets of this nature quite useful for patient education.

Deane C. Manolis, M.D.
Clinical Associate Professor of
Psychiatry
University of Minnesota
Minneapolis, Minnesota

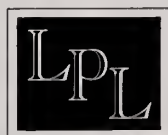
800 No-Load Mutual Funds

Professional Management Through Asset Allocation

One Consolidated Statement

No Commissions*

*If this sounds like a better way to invest, call today
and ask me about our SAM program.*



ADVISORY
SERVICES

Wayne E. Bernardo
2500 Foshay Tower
Minneapolis, MN 55402
(612) 337-8484
(800) 755-5877

*Investors in SAM pay a small annual fee based on account value; nominal transaction costs occur.
LINSCD/PRIVATE LEDGER A REGISTERED INVESTMENT ADVISOR

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Kristi Belcamino

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Frank A. Bures, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussy, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.

President-Elect
Michael J. Murray, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Ophelia Balcos

Board of Trustees

N.W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legal Affairs
Mary E. Prentnieks, J.D.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

Telemedicine Beckons

Charles R. Meyer, M.D.

*What potions have I drunk of Siren
tears,
Distill'd from limbeck's foul as hell
within,
Applying fears to hopes, and hopes
to fears,
Still losing when I saw myself to win!*

William Shakespeare
Sonnet 119



"There is a suspicion
that technology is all
promise and no
performance, that the
proliferation of
electronic gadgets
complicates an
already-baffling
world."

Is technology a Siren? Singing an alluring song that promises power and pleasure, technology seems an irresistible force driving our future. It whispers that our lives will be easier, better, and more enriching because of its benefits. But there is a suspicion that technology is all promise and no performance, that the proliferation of electronic gadgets complicates an already-baffling world.

No product of technology has received more ink in recent years than the "information superhighway" (renamed the information superslab by my witty sister-in-law). In this month's *Minnesota Medicine*, we present two articles about one lane of the superhighway, telemedicine. Our cover story provides an overview of state telemedicine ventures (page 10), and our clinical article on page 19 addresses how telemedicine will play in rural Minnesota. Like most buzz words adopted, applied, and overused by the media, the information superhighway has lost its definition. What is the superhighway and where does it intersect medicine? To help answer these questions, I offer some real and imagined medical applications.

The Internet: This is the prototype of the highway. Originally a quasi-anarchical network of academic and government center computers,

Internet is rapidly becoming the main pavement of the highway. Internet is not a single road but a complex international web with lots of different routes between two places. Right now you can get CME credit by viewing MRIs from Washington University, instantly send "e-mail" to any other M.D. who is plugged in, or participate in more than 30 medical discussion groups. Spurred by the push for a superhighway, Internet participation is expanding exponentially, and medicine is involved.

The computerized medical record: As discussed in-depth in the August 1994 *Minnesota Medicine*, most of the information physicians handle daily is being digitized. What this means for the future is that x-rays, lab results, clinical notes, hos-

pital reports, and pharmacy prescriptions and refills will rarely hit the printed page. Information will be entered once, will travel electronically, and will be viewed on screen. This is happening now at Harvard Community Health Plan and will be the rule soon.

E-mail: You have to experience the immediacy, conciseness, and fun of e-mail to understand it. For it to work, however, the computer must be a main base of operations where you spend much of your time. You can't get the mail if you don't check your mailbox.

The facsimile: Eight years ago, when our office bought its first fax machine, many docs thought we were crazy. Now, who can practice medicine without one? This is an example of technology whose usefulness is so compelling it becomes a standard in a short time.

Telemedicine: As telemedicine demonstrates, the highway can also be a "skyway." Not all links in the information superstructure will travel by land line; satellites form part of the information network.

Clearly, the information superhighway is not one ribbon of communications, but an increasingly complex skein of channels—like a developing central nervous system. Equally clear is my bias about its utility. As an unrepentant techie, I use it now and try to integrate it further in my daily work.

Shakespeare wrote of limbeck's (an alembic is a distilling device) producing foul tears from Sirens who confused our hopes and fears. Technology is conjuring up our future. It beckons us with an alluring message. If we understand its power and its limitations and if we dare to apply it to our daily tasks, it will brew a better, clearer future.

MM

Mayo Doc Inspires MULTI-CULTURAL CARE

*For family physician
Walt Franz, the future
of medicine is here and
now—treating under-
served patients and
expanding students’
horizons.*

Dr. Walt Franz breezes into the old auto parts store. It’s past 6 p.m. and he’s running late.

After a long day of seeing patients at Mayo Clinic in Rochester, the family practice specialist prepares to see more patients at a makeshift clinic in Blooming Prairie. Located some 30 miles southwest of Rochester, the small farming community is a temporary home to many migrant workers from southern Texas who work in the fields or at the nearby canning companies. It’s the migrant workers and their families Franz comes to see.

National health system reform may be in limbo, but at a grass-roots level, Franz is doing his part to inspire a new generation of family physicians to provide care to patients who traditionally have had inadequate services. From May through September, Mayo medical residents, students, and other medical staff accompany Franz each Wednesday night to provide free medical care to patients who speak little or no English. Local translators help when possible. Franz calls his work in Blooming Prairie “tabletop medicine, high-level triage.” He sees patients with minor problems, such as colds or back pain, as well as patients with chronic diseases such as diabetes.

Migrant Health Inc. of Moorhead runs the federal migrant health program in Minnesota and oversees the Blooming Prairie clinic. However, Blooming Prairie differs from other federal migrant health clinics in which Franz and his staff volunteer their services. Mayo Clinic provides medical supplies. “This arrangement saves everybody money. We keep patients with minor problems out of emergency rooms, and patients don’t use their entire medical allowance up all at once,” Franz says. For some patients with chronic illness, this is their only opportunity to get needed medication.

The Blooming Prairie clinic also allows Franz to combine two of his passions—working with people from other cultures and teaching medicine. Franz is interested in a project only if it involves medical students and residents. “Working at Blooming Prairie is a good lesson for physicians in their formative years. What they see here is more the norm than the exception,” says Franz. Students find they can accomplish a great deal using basic tools, such as a stethoscope and patient education, and without using so many tests. “I encourage students to think on their feet, to get involved in patient advocacy issues and rights—not only in the emergency room, but on the job, as well,” says Franz.

Franz’s interest in other cultures stems from growing up in a racially mixed neighborhood, where he worked at his family’s

BY REBECCA C. GONZALEZ-CAMPOY

poultry business in St. Louis, Missouri, during the volatile 1960s. Teaching him to appreciate and learn about other cultures is "the greatest gift my parents gave me," says Franz. A graduate of William Jewell College in Liberty, Missouri, Franz completed medical school at the University of Missouri–Columbia School of Medicine in 1979.

Franz was among the first class of residents to complete Mayo Clinic's newly formed family medicine residency program in 1981. He became involved in multi-cultural medicine soon after joining the Mayo Clinic staff, when a retiring Mayo family physician invited him to learn about providing care to the Southeast Asians who were resettling in Rochester. "The more I did, the more fun I had," Franz recalls. He began making house calls for patients who were too isolated to come to his office. Eventually, more and more Southeast Asian patients began coming to him for care. Many of them spoke no English.

Language need not be a barrier. To be sure, Franz has picked up a few words from other languages along the way. He even took a Spanish conversation class. However, he's the first to admit he is not bilingual. "All you have to do is use good common

sense when dealing with patients," says Franz. "And it never hurts to show you care, you have time for them, and you are concerned. I haven't felt limited by language issues except when the patient has sensitive problems—mental illness, chemical dependency, or abuse, for instance."

His restlessness is what keeps Franz fresh. He seriously considered pursuing a law degree to be a better advocate for his patients. However, keeping his practice at Mayo while going to law school was not possible. Instead, he organized New Horizons, a program that allows medical students and staff to provide free care to patients in underdeveloped countries. Soon after the Gulf War in 1991, he joined a U.S. Army Reserves Medical Department Regiment and is now a major. "I was 17 when I entered college, so I wasn't drafted for the Vietnam War. I joined the Reserves to give something back to my country," Franz says. So far, he's been to the Dominican Republic, Haiti, Guatemala, and Comoros (an island be-

"Medicine is not a career for me.

It's a lifestyle. The future of medicine is right here—caring for patients who are underserved."

—WALT FRANZ, M.D.

tween the eastern coast of Africa and Madagascar) through New Horizons and the Reserves.

Franz believes volunteering is an important component to health system reform. He leads by example. The Blooming Prairie clinic came about three years ago when Franz and a group of medical students were looking for some way to help others closer to home who were not receiving mainstream care.

Prairie Island Community Approaches Mayo

Another opportunity for medical outreach came about last June, when members of the Prairie Island Dakota Community initiated

FRANZ continued on page 30



PHOTOGRAPH COURTESY OF MAYO CLINIC

Join professional tracer Michael Nordberg as he dons his Sherlock Holmes cap in a worldwide search for a study patient lost to follow-up.

— by P. Michael Nordberg

Lost to Follow-up: A Detective Story

My name: Michael Nordberg, professional tracer. My job: locate study patients lost to follow-up. It's a job with which few people are familiar; even my clients wonder just what I do.

Not long ago, the principle investigators and coordinators for a cryo-retinopathy of prematurity study asked me to describe the strategies I use to locate missing patients. I offered them the "case history" for a patient I tracked across the globe—an abbreviated version of the 81 steps it took to find this patient lost to follow-up. The story goes something like this:

IT WAS A DAY LIKE ANY OTHER when the Cryo-ROP study coordinator appeared at my office door, paper in hand. The clues were sparse: a patient's name, Michael Allemand*; the mother's name, Ivona Brat; the mother's former employer, the Spaniel Bar. She informed me that the mother had moved back to Poland a year ago. That was it. My mission: find the child so a follow-up examination could be performed. I began establishing the facts and gathering clues.

I first checked the phone book and called directory assistance. No listing.

The Medifax showed that the patient was not currently on Medical Assistance.

When I received the patient's chart from Medical Records, I learned three things: 1) a former address, 2) the mother's middle initial (M), and 3) the referring physician.

The referring doctor's secretary checked the patient's medical record. Nothing.

The cross directory provided names of individuals living at and near the mother's former address. These people didn't know the patient or mother.

Undaunted, I turned my attention to the hospital's billing information. Unfortunately, all information had been purged.

The afternoon bartender who answered the phone at the Spaniel Bar remembered Ms. Brat, but he didn't know her. However, the day barkeep, Bonnie, knew her well and could be reached in the morning.

I started checking businesses near Ivona's old apartment building. Keith at the neighborhood child-care center had been Michael's day-care provider. He verified that Ivona and Michael had moved back to Poland shortly after Michael's father died. T & G Hair Design and Amand's Exotic Food Market were familiar with the names but knew nothing more.

Next on my list of contacts were businesses near the Spaniel Bar. John at Kong's Restaurant had never heard of Ivona. I called the neighboring MEP Publications and discovered the business's full name—Marxist Education Press—but that was all. Northern Sun, 3 and Company, and Diamonds Plus knew nothing about the woman I described. Ivona had not worshipped at the near-by Temple of Faith.

The collection agency we used requested a credit bureau report showing any like match for the name Ivona Brat. The report had an address only a year old—a promising discovery, consider-

*Names of the patient and family have been changed.

ing Ivona had moved back to Poland about a year ago.

From the cross directory, I found all the people living in the apartment building at the address and began calling each resident. A Mrs. Lere knew the landlord and caretaker. I left messages for both.

DAY 2: MY FIRST MORNING CALL was to Bonnie at the Spaniel Bar. Bonnie corroborated the facts: Ivona

and Michael moved to Poland, where Ivona's mother lived. However, Bonnie believed that Ivona was now living and working in Holland as a cabaret entertainer, while Michael was still in Poland with his grandmother. Bonnie had no address or telephone number.

Now what? I presumed the name Brat to be Polish and began working with the Polish community. The Polish National Home Association referred me to Mr. Kazimierz Halak. The Polish Palace had no information. The Polish White Eagle Association knew only that she was not insured by them. The Polish American Club didn't know Ivona. The Polish National Alliance referred me to its Chicago office. This trail was leading nowhere.

Taking another tack, I decided to check out the patient's name, Allemand. Remember, the patient and the mother had different names. Mrs. William Allemand, found in the phone book, had heard of the family. She knew the father was a French ballet dancer. Her son had once received a misdirected letter to Michael Allemand. I followed that lead, but the son never returned my calls.

Mr. Halak from the Polish National Home Association now returned my call and referred me to Chester Rog, who mails packages from the Polish community in Minnesota to relatives in Poland—apparently it's quite a feat getting packages into Poland. If Ivona had ever sent anything to her mother, he

DETECTIVE cont. on page 32



ILLUSTRATION BY ANDREW POWELL

Tuned-in to Telemedicine

The technology that brings us e-mail and interactive video also delivers health care.

By Robert Carlson

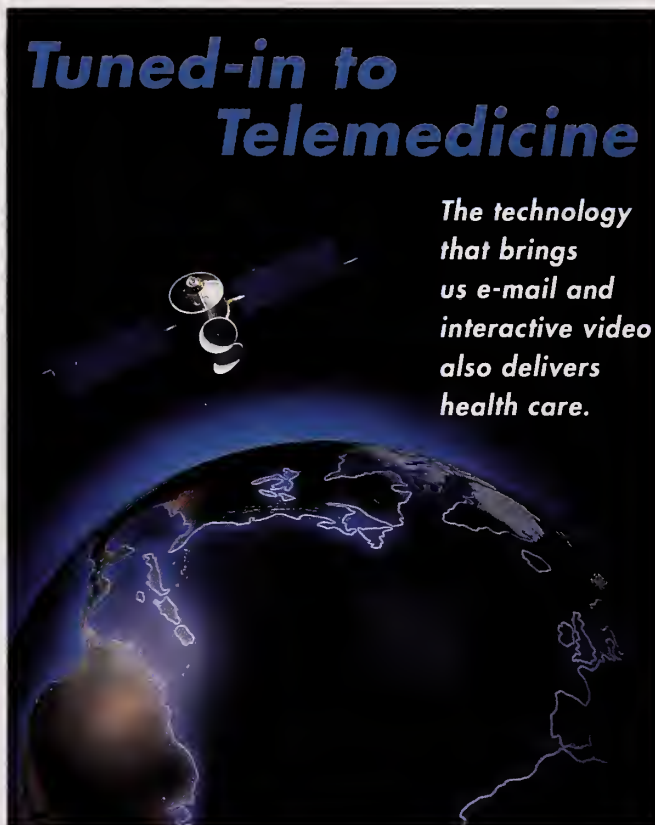


IMAGE BY MICHEAL SIMPSON, FPG INTERNATIONAL

In the 1960s, when communications guru Marshall McLuhan speculated about a future where everyone would

be linked to everyone else in an electronic global village, it sounded interesting, but improbable.

Besides, what would we possibly want to communicate that we couldn't say over the telephone?

Reggie Cedar Face can answer that. Four years after undergoing quintuple cardiac bypass surgery, he got a telemedical checkup and a clean bill of health from Mayo Clinic cardiologist Bijoy Khandheria. Even though Cedar Face and his primary care physician were in Pine Ridge, South Dakota, and the cardiologist was in Roch-

ester, Minnesota, the consultation took place as if all three were in the same room.

"I was able to use an electronic stethoscope," says primary care physician Julie Dixon, D.O., "and because the satellite picture is so clear, I could show Dr. Khandheria Mr. Cedar Face's most recent chest x-ray, EKG, and even an echocardiogram."

From the Village to the Highway

McLuhan was right, of course, but instead of a "global village," we have a new metaphor for the electronic telecommunications network he envisioned. Today, we call it the information superhighway. This highway moves information, not people. It brings us videoconferencing, the Internet, e-mail, and computerized information services such as CompuServe and America Online.

The technology that brings us entertainment and interactive merchandising also delivers medical care. Telemedicine, as it's called, uses the video, computer, and networking technology of the information superhighway to deliver health care. In its strictest sense, telemedicine means live, two-way audio and visual communication between physician and patient, or between physician and physician. Using state-of-the-art telemedicine in 1995 approaches the experience of being together in the same room. With its ability to "zoom in," telemedicine can in some situations provide greater detail than direct examination. The tympanic membrane, for example, can fill an entire video monitor.

In a broader sense, telemedicine also includes interactive video and audio in education and research and the transmission of still images and data. Pathology, cardiology, psychiatry, pharmacology, administration, credentialing, and utilization review are all potential beneficiaries of telemedicine. X-rays, for example, have been electronically transmitted from hospitals to radiologists' homes for nearly a decade. An emergency physician gets a radiologist's interpretation via telephone in a matter of minutes, and the radiologist avoids driving to the hospital to look at the actual film radiograph.

Teleradiology is telemedicine, too. But instead of people interacting, instead of the physician retrieving information from the patient's electronic chart, or using a variety of endoscopes, taking video photographs, or examining EKGs, teleradiology uses much less equipment to transmit a still monochrome image one way.

Equipment and transmission are critical factors in telemedicine right now because they cost money. Lots of money. Systems consultants alone charge between \$75 and \$250 an hour. In her pioneering "The Telemedicine Handbook: Improving Health Care with Interactive Video," Jane Preston, M.D., estimates the start-up hardware costs of a "bare-bones" system for each rural hospital or clinic in a network at \$50,000. She estimates transmission costs, which she bases on rates from telephone carriers in central Texas, at between \$1,400 and \$2,000 a month. An urban tertiary care center may need a much more sophisticated—and expensive—system with much higher transmission rates. Until these costs fall substantially, the name of the game in telemedicine is

choosing the right combination of equipment and mode of transmission for the job.

Currently, digital satellite-based telemedicine is being done only on an experimental basis with the National Aeronautics and Space Administration's Advanced Communication Technology Satellite. By comparison, land lines are much less expensive. Land lines can be relatively inexpensive copper telephone lines or more expensive fiber-optic cable—if fiber has been installed in the area. In rural and remote areas, it may be years before fiber-optic service is available.

It all comes down to how much data (expressed in *bits*) you want to send. The greater the transmission capacity, or bandwidth, the higher the cost. In video transmission, the trade-off is between image quality and cost. A relatively small volume of data, such as an x-ray, can be transmitted over copper telephone wire using digital compression technology, which eliminates what the computer decides is redundant data. If you want to transmit a CT scan that consists of 30 images, you need more bandwidth—and even more yet to handle the

enormous data transmission requirements of state-of-the-art, live, interactive telemedicine.

What combination of transmission line and digital compression is acceptable for telemedical examination and diagnosis? How many pixels on a video monitor does it take to produce an image at least as detailed as a film radiograph? Is an electronic stethoscope an acceptable substitute for the real thing? When is telemedicine an acceptable substitute for face-to-face communication between doctor and patient? These and scores of other questions (see sidebar, page 15) about the use of this revolutionary new technology are being answered in telemedicine demonstration and evaluation projects underway across the country.

Such projects are reaching out to touch physician practices throughout Minnesota. Reggie Cedar Face's electronic office visit was part of Mayo Clinic's Pine Ridge Telemedicine Project, one step in an ambitious five-year program to create an electronic environment for the clinic and its regional practices. In the Twin Cities, nurses are making "video visits" to home care patients with American TeleCare's personal telemedicine systems. In the central and western parts of the state,

"We need to figure out what telemedicine is good for and what it isn't good for—what we're comfortable with, and what we're not comfortable with."

—MARGARET HOUSTON, M.D., M.P.H.

the new Minnesota Rural Telemedicine Project will make the University of Minnesota's expertise available to rural health care centers in four rural communities. And in west-central Minnesota, physicians in eight communities will soon be linked with Allina Health System sites in the Twin Cities.

Mayo Clinic's Five-Year Program

Uplinks and downlinks are nothing new for Mayo. Its three campuses in Rochester, Minnesota; Jacksonville, Florida; and Scottsdale, Arizona, have been linked by the clinic's own satellite-based analog video system, the same technology used by commercial television networks, since 1987. According to Bijoy Khandheria, M.D., a cardiologist with Mayo Clinic in Rochester and chair of the clinic's Electronic Environment Council, the clinic has embarked on a program to expand and integrate its digital satellite and land-based telemedicine network. One of the objectives is to collect data on telemedicine over the long term.

"In the next four to five years, we plan to be an electronic clinic, that is, with electronic links to all of our extended family members, other clinics that are part of the system, or that are in any way related to the system," says Khandheria. "And that obviously includes telemedicine links."

The clinic's five-year telemedicine program started in 1994 when the National Aeronautics and Space Administration (NASA) and the Advanced Research Projects Agency (ARPA) asked Mayo to collaborate in three demonstration and evaluation projects of two, three, and nine months' duration using the recently launched experimental Advanced Communication Technology Satellite (ACTS). According to Khandheria, who is the principal Mayo investigator for the ACTS projects, the satellite is designed to complete the digital communication grid for areas without fiber-optic lines.

The Wabasha project

The first of the three ACTS projects lasted eight weeks in the spring of 1994 and linked the clinic's Rochester campus with one of its regional practices, Wabasha

Clinic in Wabasha, Minnesota. Dialysis patients in Wabasha were monitored by nephrologists in Rochester; speech disorders were diagnosed and treated by Mayo speech pathologists; and x-rays were transmitted for interpretation by Mayo radiologists. "The quality of care was found to be acceptable by physicians at this end, physicians at the other end, and, more importantly, by the patients at the other end," says Khandheria.

The Pine Ridge project

The Pine Ridge Indian Reservation was Mayo's partner for the second ACTS project, which lasted from June to September of 1994. Nestled in the southwest corner of South Dakota, the 5,000-square-mile reservation is about an hour's drive from Rapid City and 500 miles from Rochester. This is Lakota country. Wounded Knee is just a few miles up the road from Pine Ridge Indian Hospital, a 45-bed acute care center and community health service headquarters for the 25,000 people on the reservation. The service unit director of the hospital, Leonard Little



Bijoy Khandheria, M.D., Mayo Clinic, Rochester

Finger, is the great-great-grandson of Chief Big Foot, one of the Wounded Knee survivors.

"Most of the health problems we have require further specialized consultation or treatment," says Little Finger. "Our closest referral center is in Rapid City, which presents some unique problems in terms of transportation and expense. But the satellite hookup this project made available gave our physicians almost instant evaluations."

Three days a week, Mayo Clinic staff liaison Mary Alice Trapp, R.N., M.P.H., coordinated 75-minute tele-

medicine clinics at Pine Ridge Hospital with specialists and subspecialists at Mayo. In some consults, physicians at Mayo interacted with a patient and primary care physician at Pine Ridge Hospital, as in the case of Reggie Cedar Face. When patients were not able to come in, their primary care physicians or Trapp reviewed their cases with the appropriate Mayo physicians. One of these patients was Little Finger, who, as a result, is now on insulin, and his diabetes is under control.

Continuing medical education was another component of the project. The medical staff at Pine Ridge Hospital chose topics for CME sessions, according to Nancy Gilliland, R.N., a patient educator in Mayo's Department of Patient Health and Education and a coordinator for the allied health education component of the project. She says the CME presenters at Mayo were briefed about the sociology, history, and geography of the reservation to help them bridge cultural differences. Presenters and their counterparts at Pine Ridge Hospital included physicians, nurses, counselors, nutritionists, and administrators.

"That was probably the most valuable thing to all of us, right up there with patient care," recalls Cedar Face's physician, Julie Dixon, who is also director of field clinics and the Outpatient Department at Pine Ridge Hospital. "When you are out in remote areas, you don't always have access to continuing medical education. You can order tapes, but you can't interact with a tape. Here we had questions and answers, interaction back and forth."

In terms of providing a geographically remote population with access to specialists, delivering quality care, and gaining patient and physician acceptance, the Pine Ridge Telemedicine Project was very successful, according to Khandheria. In fact, Mayo is interested in working with the Pine Ridge community to establish a permanent telemedicine link.

The long-term cost-effectiveness of such a link has yet to be determined. Using fiber-optic land lines instead of satellite transmission is one way to save money. But the equipment is still expensive. "I think right now you're talking in excess of \$100,000 just for equipment," says Little Finger. "That's an area we're exploring right now. Our dollars come solely from congressional appropriations, so we would have to put a plan in place; [it] would take several years to go through the process. Or we can go the grant route."

A hybrid project

Mayo's third telemedicine project with the ACTS satellite is scheduled to start in October 1995 and will use a system recently deployed by the Department of Defense and NASA. It is a hybrid of global high-speed asynchronous transfer mode (ATM) and synchronous optical network (SONET) communication technology, which takes advantage of existing fiber-optic lines, with the satellite filling in the gaps.

Three institutions will work with Mayo on this project. Using a multimodality approach that includes angiograms and echocardiograms, Mayo physicians will consult with the Children's Hospital in Phoenix, Arizona, on patients with congenital heart disease. The second phase will attempt to answer some basic questions about the use, outcomes, system design, and cost of tele-

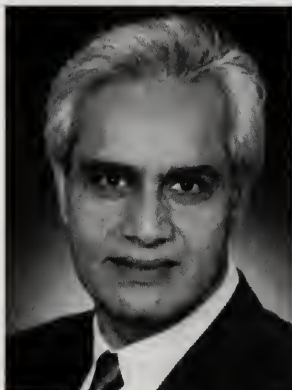
medicine by working with a family practice clinic in either Arizona or Iowa on cardiovascular diseases, skin diseases, and congenital heart disease. Mayo's third site will be the Midelfort Clinic in Eau Claire, Wisconsin. The purpose there, according to Khandheria, is to see if specialists can reliably interpret cardiac catheterization and ultrasound images telemedically.

Hub-and-spoke regional networks

In addition to its satellite-linked telemedicine capabilities, each of the three Mayo Clinic campuses is also developing land-based "hub-and-spoke" telemedicine networks closer to home. For the Rochester campus, one of these regional practice sites is Kenyon, about 50 miles away.

Nurse practitioner Jay Fotland has been seeing patients at Kenyon Mayo Family Practice Clinic for the last two years. Since January, he's been supported by electronic medical records and a land-line telemedicine link with Rochester, including an electronic stethoscope, a derm scope, and ECG transmission capabilities. Although numerous telemedicine projects have involved subspecialists, few have involved nonphysician practitioners, such as physician assistants and nurse practitioners like Fotland backed up by primary care physicians.

"We need to figure out what telemedicine is good for and what it isn't good for—what we're comfortable with, and what we're not comfortable with," says Mayo family physician Margaret Houston, M.D., M.P.H., coordinator and principal investigator for the Kenyon



Khalid Mahmud, M.D.

project. "I think it is potentially a very valuable way of providing excellent care to underserved rural communities that otherwise can't afford it."

Bringing Telemedicine Home

Khandheria agrees that telemedicine will change the way medicine is practiced in urban, as well as rural areas. He predicts, for example, that doctors in the future will be making house calls—electronic house calls.

In fact, home "video visits" are already a reality for 10 patients in the Twin Cities. That's how many personal telemedicine systems have been installed on a trial basis, according to Khalid Mahmud, M.D., founder and president of American TeleCare. Whereas Mayo's telemedicine spans the country with state-of-the-art video, audio, and data transmission capabilities, American TeleCare's systems link home-care patients with providers in the same city.

About the size of a small microwave oven, a personal telemedicine system (PTS) allows home-care nurses to communicate with their patients via two-way video and audio. Nurses can look at a wound, an intravenous site, or an insulin syringe. They can check blood pressure and pulse or use an electronic stethoscope. Mahmud says additional diagnostic capabilities are being developed. The PTS unit also includes an emergency response and automatic emergency voice communication system.

"We have created a new tool in the delivery of home care," asserts Mahmud. "The technology is relatively simple and gives us enough clinical information to be of real use. The PTS does basically everything home-care nurses do when they go into a patient's home, except for hands-on things such as changing a dressing or starting an IV."

Mahmud makes a distinction between relatively expensive institutional telemedicine and relatively inexpensive home telemedicine, such as his personal telemedicine system, which uses ordinary telephone lines. Eventually, he thinks, the two ends of the telemedicine spectrum will be integrated as the cost of institutional telemedicine declines. The advantage of American TeleCare's PTS units, Mahmud emphasizes, is that they cut the cost of home care dramatically right now, in addition to enhancing access and reducing emergency department admissions and hospitalizations. Major third-party pay-

ers in the Twin Cities area have agreed to pay for care via PTS units on a case-by-case basis, says Mahmud, and Medicare reimbursement is pending. Mahmud believes American TeleCare's PTS is the first product of its kind for the home-care market.

"I think telemedicine will play an important role in the delivery of health care in this country," Mahmud predicts. "It will eventually reduce the cost of care and improve access. But we're not there yet. The technology in institutional telemedicine has to become cheaper. Right now that technology is working because of the availability of grant money."

Minnesota Rural Telemedicine Project

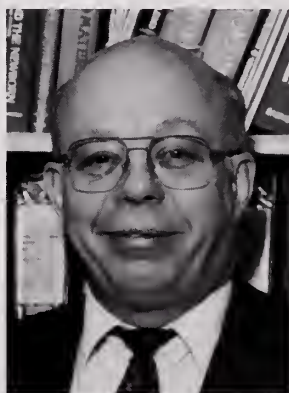
The University of Minnesota's Minnesota Rural Telemedicine Project (MRTP) is among the many telemedicine projects funded by grants from various agencies of the federal government. Its grant is one of 11 awarded to universities and hospitals throughout the country by the Office of Rural Health, Department of Health and Human Services, to fund telemedicine demonstration and evaluation projects. Like all the projects given this grant, MRTP links very small rural communities with secondary and tertiary care hospitals.

The project is funded by a three-year grant, explains David Garloff, director of Health Sciences Learning Resources at the University of Minnesota. "The first-year federal share is \$294,000; the second year it's \$332,800; and the third year it's \$394,200. So we're just over \$1 million total."

During its first year, which began in September 1994, the MRTP will link Tri-County Hospital in Wadena and the

Wadena Clinic with the University of Minnesota Hospital in Minneapolis. In the second year, Lake Region Hospital, a secondary care hospital in Fergus Falls, will be connected with Wadena Hospital and the University Hospital. In the third year, Henning Clinic in Henning will be linked with Fergus Falls. Garloff says that the "laddering" of very small rural to secondary to tertiary care hospitals is a telemedicine network model the university hopes to duplicate in other parts of the state.

In addition to delivering care, these telemedicine links will also be used for administrative conferences and by Rural Physician Associate Program students, nursing students, and pharmacy externs to meet with their facul-



Theodore Thompson, M.D.

ty advisers. "This is a method for bringing university health care services to the citizens of greater Minnesota," says pediatrics professor Theodore Thompson, M.D., head of medical outreach at the University of Minnesota Health System and one of MRTP's three investigators. "I also believe that it's extremely important in the education and retention of physicians in those areas."

Rural Health Alliance/Allina Telemedicine Project

Also working together on a telemedicine project are the Rural Health Alliance (RHA), a consortium of eight hospitals in west-central Minnesota, and the Minneapolis-based Allina Health System. The Rural Health Alliance/Allina Telemedicine Project will link physicians in RHA's eight rural communities with specialists at Allina sites in the Twin Cities metropolitan area. Allina will fund the installation and development of the Twin Cities portion of the network, and RHA will use grant money to fund its portion.

"As a corporation, we believe we have a responsibility to help improve the quality of health care for the state of Minnesota," says William Goodall, M.D., regional



William Goodall, M.D.

vice president for medical affairs with Allina Health System. "As we look toward managed care and capitated medicine, having a strong statewide network of providers and patient base also makes good business sense. With the Rural Health Alliance/Allina Telemedicine Project, we're starting to develop that."

The Rural Health Alliance has a \$642,000 grant from the Health Resources and Services Administration's Office of Rural Health Policy to administer the project, develop and implement the network and regional programs, and monitor and analyze project performance.

Of the RHA's eight hospitals, St. Michael's in Sauk Center, Douglas County Hospital in Alexandria, and Grant County Health Center in Elbow Lake are scheduled to join the RHA/ATP network in May 1995. Stevens Community Medical Center in Morris, Long Prairie Memorial Hospital in Long Prairie, and Minnewaska District Hospital in Starbuck will follow in December.

Both Sauk Center and Elbow Lake are federally designated Health Professional Shortage Areas. Goodall expects the telemedicine project will help these communities retain physicians. "We expect the system to de-

Demonstrating the Value of Telemedicine

Payers want convincing, long-term data showing efficacy and cost-effectiveness before they'll reimburse providers for telemedical consults and procedures. With the exception of teleradiology and telepathology, such data are lacking, according to Michael Wood, M.D., professor of orthopedic surgery at Mayo Clinic and chair of the Mayo Foundation Communications Committee. Billions of dollars annually hang in the balance. For federally financed programs such as Medicare and Medicaid, the Health Care Financing Administration (HCFA) decides who gets paid, under what conditions, and how much. Private payers usually follow HCFA's lead.

What kind of data is HCFA looking for? "Cost-effectiveness, patient acceptance, whether quality of care appears to be at least equal to care given in more conventional ways—all the things you'd want to

know before you'd start getting all your medical care through telemedicine," answers Helen Smits, M.D., deputy director of HCFA in Washington, D.C. "I've been very impressed by how enthusiastic doctors have been, particularly in remote rural sites, about telemedicine's ability to provide them with support they just haven't had before" (see related article, page 19).

While scores of demonstration and evaluation projects around the country accumulate the evidence, proponents of telemedicine are making their case in Washington, D.C., and addressing other issues related to telemedicine, such as patient confidentiality, clinical transmission standards, legal jurisdiction, tort issues, and interstate licensure.

Since its establishment in 1992, the American Tele-

Value of Telemedicine continued on page 16

crease the isolation of rural physicians and to improve opportunities for medical education. We also expect the network will increase the amount of time family physicians spend in training in rural communities. We know additional training time in a community often has a significant impact on the decision a physician might make to remain in rural practice," he says.

Like the Minnesota Rural Telemedicine Project, with which it will coordinate operations, the RHA/Allina Telemedicine Project uses land lines exclusively and will collaborate with Minnesota Equal Access Network Services, Inc. (MEANS), which is owned by 58 independent rural telephone companies in Minnesota, and with US West, for network design, installation, management, and maintenance.

Communities involved in the project are expected to benefit not only from the clinical and teleradiology components, but also from continuing medical education, resident rotation support, administrative applications, community development, and community education. In its grant application, the RHA estimates annual savings of more than \$659,000. That figure includes savings from providing local CME classes and treating patients locally instead of referring them out, as well as administrative savings. "It is evident," the grant application reads, "that the potential financial impact of telemedicine services on RHA's participating rural commu-

nities is substantial and could play a critical part in the long-term financial viability of rural health care systems in general."

Goodall, whose own career includes 15 years in a rural family practice, believes this is a remarkable time for the rural physician. "Telemedicine technology is developing at an incredible speed. Rather than being isolated and a long way from what's happening, the rural physician is now becoming the center of the action. The large systems are going to begin courting the rural communities, and I think that's a marvelous situation for the rural physician and the rural patient to be in."

Initial data from telemedicine projects in Georgia and Texas, among others, seem to bear out Goodall's optimism. Telemedicine has, indeed, brought rural physicians more patients and an end to professional isolation. Telemedicine also promises the 100 million medically underserved Americans who live in rural communities access to state-of-the-art health care. For the managed care industry, that's a previously inaccessible market of 100 million potential customers. For many rural communities in Minnesota and elsewhere, telemedicine is likely to be the first link with the information superhighway and the economic benefits it can bring. MM

Robert Carlson writes for health care journals throughout the United States. He telecommutes from Indianapolis.

Value of Telemedicine continued from page 15

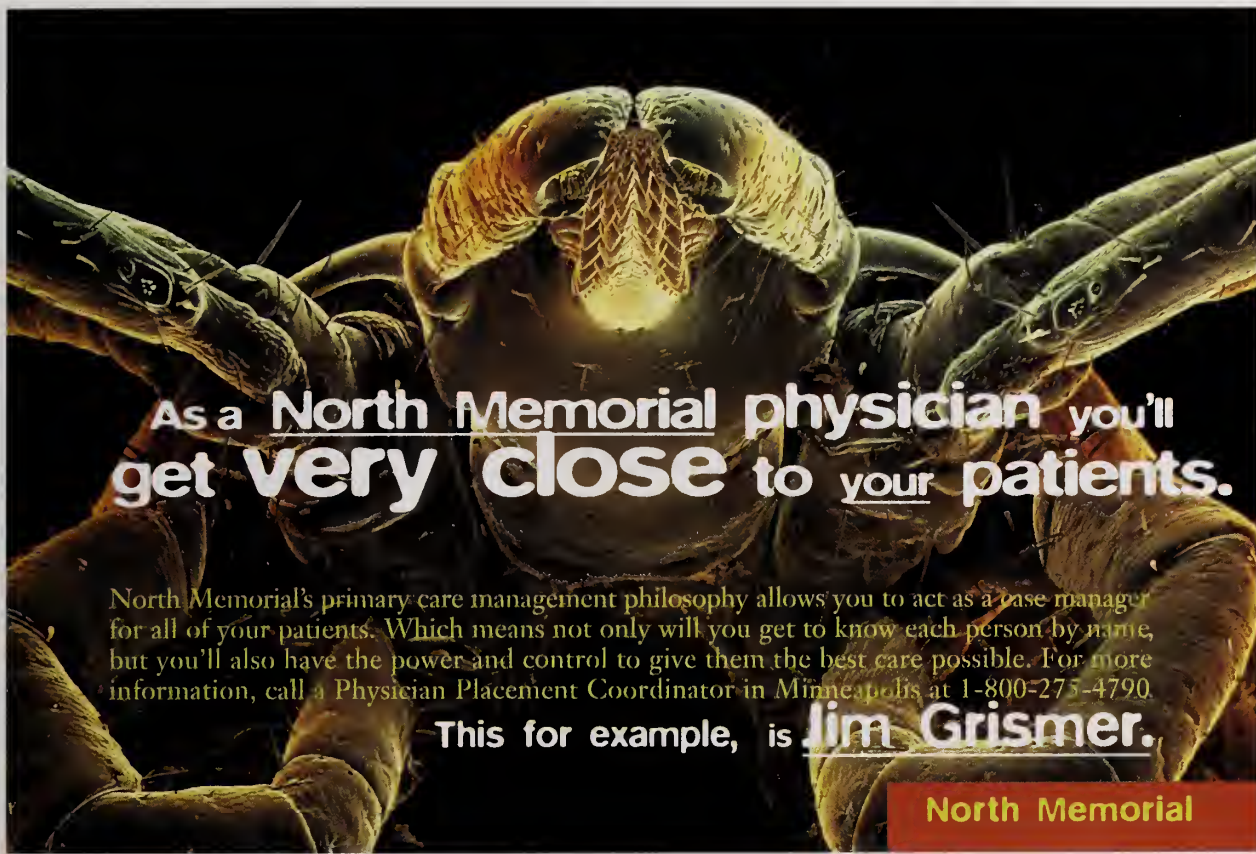
medical Association (ATA) in Austin, Texas, has been an influential advocate of telemedicine with government and organized medicine, as well as an invaluable resource for reliable information about telemedicine. The ATA board of directors, headed by Texas Telemedicine Project founder Jane Preston, M.D., is a veritable "Who's Who of Telemedicine" in the United States.

Mayo Clinic has also been a driving force nationally in making the promise of telemedicine a reality. Eric Tangelos, M.D., associate professor of medicine at Mayo Clinic, is on the ATA board of directors and serves on the Mayo Clinic's Systems Communications Committee. Tangelos has testified on telemedicine before Congress and is course co-director for the Second International Conference on the Medical Aspects of Telemedicine, which will be hosted by the

Second Annual Mayo Telemedicine Symposium, April 6-9, 1995. The meeting will take place simultaneously in Rochester, Jacksonville, and Scottsdale, and may include presentations from Washington, D.C., and Camp Pendleton, California. There are also plans for physicians in Athens and Madrid to receive portions of the program.

"The culture at Mayo has already moved along so that our physicians are fairly comfortable doing telemedicine," says Tangelos. "We've started to address the issues that the nation will face concerning licensure and reimbursement and where you can practice and how you can practice. We are also looking at how much of an image you need to make a diagnosis and how much you can leave behind in a compression algorithm."

These are exactly the issues that telemedicine projects here in Minnesota and around the country are designed to resolve.



As a North Memorial physician you'll get very close to your patients.

North Memorial's primary care management philosophy allows you to act as a case manager for all of your patients. Which means not only will you get to know each person by name, but you'll also have the power and control to give them the best care possible. For more information, call a Physician Placement Coordinator in Minneapolis at 1-800-275-4790.

This for example, is Jim Grismer.

North Memorial

K
♦



Make plans to be at C.F. Anderson's Casino & Product Fair

April 13, 1994

Thunderbird Motel, Bloomington

- | | |
|---------------|-------------|
| ♥ Roulette | ♦ Auction |
| ♠ Blackjack | ♣ Good food |
| ♣ Dice games | ♠ Seminars |
| ♦ Door prizes | ♥ Exhibits |

Watch for your invite!

♦
**You are always
a winner!**



TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 260 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice for the Region
- Orthopaedics - Detroit Lakes, Bemidji
- General Surgery - Wahpeton
- Psychiatry ■ OB/GYN
- Urgent Care ■ ENT
- Rheumatology ■ Pediatrics - Bemidji
- Internal Medicine - Detroit Lakes

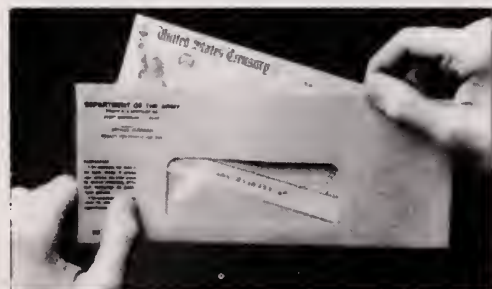


MeritCare Medical Group
737 Broadway • Fargo, ND 58123

For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor.

CALL COLLECT CPT. RICK OTTO
612-854-7702

ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®

Rural Minnesota Family Physicians' Attitudes Toward Telemedicine

Jon Kane, Jeff Morken, Jim Boulger, Ph.D., Byron Crouse, M.D., and Dale Bergeron

ABSTRACT

This study reports the results of an assessment of the attitudes and opinions of rural Minnesota family physicians toward telemedicine. The results of 52 mail surveys and 32 telephone interviews were compiled to determine existing attitudes and levels of awareness concerning aspects of telemedicine.

Surveyed physicians overwhelmingly agreed that they do not have sufficient information about telemedicine. Their awareness of telemedicine's applications and capabilities is minimal. Also, responding physicians indicated little knowledge regarding such important issues as cost-effectiveness, reimbursement, liability, and potential primary care benefits. In general, however, physicians' attitudes toward telemedicine were favorable.

This information should be important to funders, suppliers, and potential users of telemedicine. This study suggests a need to educate medical students, residents, and practicing physicians about telemedicine and issues related to its use.

Telemedicine has been offered as one possible solution to some of the problems currently plaguing rural health care. Currently, more than 28 million Americans live in medically underserved rural communities.¹ The Council on Graduate Medical Education has determined that a serious shortage of primary care physicians exists, especially in rural areas of the United States.² Other problems facing rural health care systems include professional isolation, lack of access to specialists, declining hospital use, discontinuity of care when patients are transferred to tertiary centers, financial difficulties, and trouble recruiting and retaining physicians. Although levels of severity differ, virtually all rural communities share similar problems.

The American Academy of Family Physicians accepts the following definition of telemedicine: "[It] can be envisioned as a mode of health care delivery—diagnosis, consultation, treatment, transfer of medical data, and education—using interactive audio, visual, and data communications."³

Rinde et al. state that "Telemedicine renders medical expertise available to more people than used to be the case; it has nothing to do with the development of new diagnostic or therapeutic procedures."⁴

Telemedicine is effective with virtually any medical specialty.⁵ Francis Tedesco, M.D., president of the Medical College of Georgia, which currently utilizes an extensive statewide telemedicine network, states, "We have interactive video communication. We do physical examinations. We can listen to the heart and lungs with electronic stethoscopes, we can see pathologic specimens, and we use endoscopic cameras. The only thing

we don't have is tactile sensation, but we are working on a sensory tactile glove."⁶ Such specialties as radiology, dermatology, psychiatry, and oncology have successfully used telemedicine, and the growing list will include nephrology, neonatology, orthopedics, and neurology.⁷ The technology is being applied to continuing medical education, medical records, and medical libraries. The technology is currently available to implement telemedicine, and it appears that widespread use could be on the very near horizon.

Telemedicine will be met with varying levels of optimism and skepticism by physicians, who have concerns about user satisfaction, quality of care, confidentiality, cost-effectiveness, legal issues, reimbursement, and time demands. Little information is available about rural physicians' attitudes concerning the use of telemedicine. Previous studies on user attitudes have been limited in scope and have been part of experimental trials of specific telemedicine techniques.⁸⁻¹⁰ The goal of this study was to assess the attitudes of rural Minnesota family physicians toward the use of telemedicine.

METHODS

The study sample consisted of 100 Minnesota family physicians from rural and non-urban sites. The population consisted of all members of the Minnesota Academy of Family Physicians, excluding those practicing in the Twin Cities metropolitan area, Duluth, Mankato, Moorhead, Rochester, and St. Cloud. One hundred names were randomly drawn from the remaining members. The survey described below was mailed to each physician in July 1994, and a reminder was sent one week later to nonrespondents.

In addition to demographic information, the mailed survey asked physicians to respond to a series of statements using a five-point Likert scale to assess their awareness of and attitudes toward the use of telemedicine. Finally, physicians were asked to evaluate the importance of 22 different types of consultations and services that may be available via telemedical technology. A scale of zero to 10 (no importance to extremely important) was used to assess the potential importance of these services in their practices.

A separate telephone survey of 31 physicians was conducted to augment responses received in the mailed survey. The telephone survey consisted of five questions:

1) What types of "hands-on" experiences have you had [with] telemedical technology? Are there any other uses that you are aware of?

2) What do you see as the possible benefits associated with its use in your practice?

3) What possible barriers do you see to the use of telemedicine in your practice?

4) How do you think the use of telemedical technology would affect your malpractice liability exposure?

5) Who do you think stands to benefit the most financially from the use of telemedicine—primary or tertiary centers?

Responses to these questions were recorded during the conversations. Results from both surveys were tabulated.

RESULTS

Fifty-two physicians returned their mailed surveys. Twenty-six (50%) indicated they practice in multispecialty groups, 21 (40%) stated they were part of a family practice group, and five respondents (10%) were in solo practice. Thirty-one (60%) said physicians in specialties other than primary care also practice in their communities.

Respondents ranged in age from 31 to 68 years with a mean age of 44.1. Years of practice ranged from one to 42 with a mean of 14.7.

Seven physicians (13%) stated they have used or are currently using some form of telemedicine. The tech-

nology was being applied in radiology, electrocardiography, orthopedics, and fetal monitoring.

The 52 physicians evaluated the relative importance to their practice of 13 different specialty consultations potentially available via telemedicine. A scale of zero to 10 was used; the mean scores are presented in Figure 1. Physicians rated radiology and cardiology as having the greatest potential value.

Forty-eight physicians evaluated nine services potentially available through telemedicine; the mean scores are presented in Figure 2. Respondents indicated that M.D./M.D. consults, medical libraries, M.D./patient consults, and education would be of greatest utility.

Responses to 12 of the 18 questions dealing with the actual use or effects of telemedicine indicated that the respondents were unsure of the benefits or effects of the technology. Generally, respondents agreed most strongly that they have insufficient information about the benefits of and barriers to the use of telemedicine.

DISCUSSION

Physicians consistently said they have not received sufficient information concerning various aspects of telemedicine. As one physician stated, "To be frank, I don't have a clue as to the capabilities of this technology." (Hereafter, references to "a physician," "one physician," etc., refer to comments received during the telephone interviews.) Most of the survey questions elicited responses indicating that respondents were "not sure" about the issues. Because physicians will be the principal users of telemedicine and will have the largest voice in determining its success, this finding is extremely important to funders, suppliers, and potential users of telemedicine.

Several physicians in the phone survey expressed concern about quality of care available to the patient via telemedicine because of the loss of face-to-face contact and the inability of the consulting physician to use palpation to aid diagnosis. One physician expressed worry about the quality of care delivered if telemedicine were "overused," because phy-

sicians "must have personal, hands-on contact to build trust with the patient." Another physician stated, "We must have hands-on contact. Telemedicine must be a tool, not the be all or end all; it should be used as an adjunct to care."

Others were more harsh in their criticism, claiming that telemedicine is not the answer to physician shortages. One rural Minnesota physician said, "Nothing in the field is quite as efficient as one family practitioner doing their job well." Another stated that diagnostics and clinical applications of telemedicine are "not an appropriate use—it is a way of selling poor quality medicine to rural Minnesota. What we really need is more good family doctors."

Conversely, many physicians expressed support for the potential ability of telemedicine to deliver quality care. One said he feels the quality of care delivered "wouldn't change much with telemedicine, because the standard of care is dependent to the greatest degree upon the relationship existing between a physician and a patient." Another physician, whose practice group was considering implementing a large-scale telemedicine operation, stated, "If you truly understand what telemedicine can be, you can see how good quality care can be delivered. You must start out with the intention that you are going to deliver good quality care to the patient. If you're serious about delivering quality care, you must be aware of the technology available and utilize it to your and the patient's advantage." Grigsby et al. in a series of 13 case studies found that providers who already are using telemedicine are generally believers in its value.¹¹

COST-EFFECTIVENESS

Ultimately, the most important issue regarding the use of telemedicine may be its cost-effectiveness. Physicians indicated little knowledge about cost-effectiveness, rural hospital profits, and reductions in rural health costs. One physician stated, "I don't see how primary centers could benefit financially." However, Jane Preston, M.D., president of the American Telemedicine Association, believes

rural hospitals can gain financially by increasing the retention of patients in the rural hospital and by providing previously unrendered services.¹²

Some physicians remain skeptical of the proposed financial benefits for primary care centers. One physician said, "The last words in most consults will be 'send [the patient] down,' " thus negating any benefits. Another stated, "Telemedicine will not help because most transfers are for special procedures." In a previous study, one physician noted that telemedicine would not prevent unnecessary transfers because "the need for most transfers was obvious and that only with hindsight could one tell whether a transfer was unnecessary."¹⁰ Some physicians have suggested that patients could be transferred for initial consultations or pro-

cedures and then be linked telemedically from their home community for subsequent checkups.¹³

Overall, physicians agreed that costs of set-up, training, maintenance, and system upgrade would be substantial barriers to the implementation of telemedicine. One often-cited source on the subject of telemedicine's cost-effectiveness is a study by the consulting firm of Arthur D. Little, Inc., which projected that telemedicine could save more than \$36 billion annually in health care costs.¹⁴ However, Grigsby cautions against accepting this study as proof of telemedicine's cost-effectiveness, stating that the design of the study "does not permit such sweeping conclusions."¹¹ Most sources agree that more studies are needed to determine cost-effectiveness.

REIMBURSEMENT

Another major issue that may well determine the success or failure of telemedicine is reimbursement. Currently, most telemedical services are not reimbursable by Medicare and Medicaid, and most private insurance companies follow their lead. Medicare statutes require that services must be "reasonable and necessary" and, to date, sufficient studies have not been conducted to determine whether telemedicine meets these requirements. As expected, surveyed physicians were unsure how telemedicine expenses would be compensated. One physician did not believe that specialists who earn money via procedures would "cooperate" because of reduced reimbursement. Another thought that specialists "may not charge for a telemedicine consult, with the assumption that they will benefit instead by the referrals." Yet another rural physician predicted that managed care would eliminate the problem with a capitated system. Currently, Georgia is the only state reimbursing some telemedicine costs, with Medicare, Medicaid, and Blue Cross and Blue Shield covering both the referring and consulting physician if the referring physician is present during consultation.¹⁵ Issues regarding reimbursement must be addressed before telemedicine can expect to gain widespread use.¹⁰

MALPRACTICE LIABILITY

Another unresolved issue concerning telemedicine is malpractice liability. Physicians in both the mail and phone surveys were of the opinion that their malpractice exposure would most likely decrease with the use of telemedicine. Many of these physicians felt responsibility would be transferred to the consulting doctor during telemedicine consultations. Others felt greater access to other specialists would increase the quality of patient care, thus decreasing liability exposure. Some physicians said they believe access to diagnostic databases, medical libraries, and other forms of education would decrease exposure. However, one physician who said he believed malpractice exposure would increase was concerned

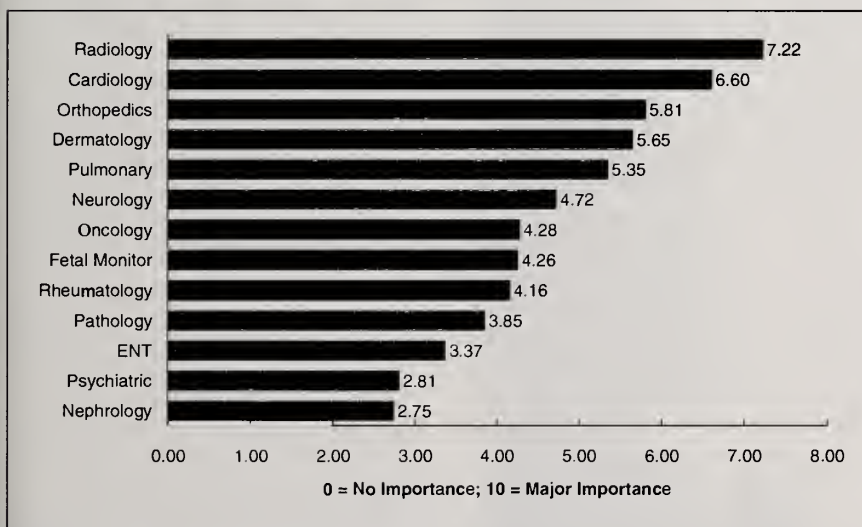


Figure 1—Average rating of perceived utility by specialty.

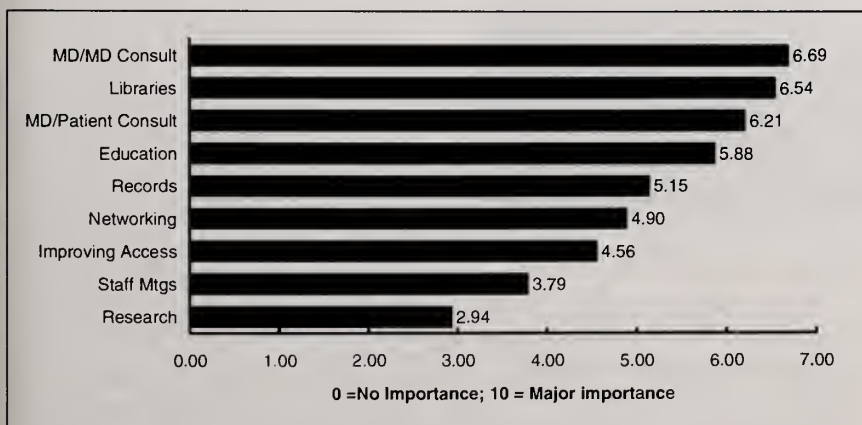


Figure 2—Average rating of perceived utility.

that doctors would be "making diagnostic calls important to patients' health without actually having their hands on the patients." In this instance, the physician believed, responsibility for the patient would remain with the primary physician, as is the case with phone consultations.

PROFESSIONAL ISOLATION

Rural physicians frequently describe a feeling of professional isolation. Physicians surveyed tended to agree more than they disagreed that a telemedicine system would help to alleviate this problem. One doctor stated, "We wouldn't be so damn isolated. We still wouldn't have specialists to rub shoulders with down the hallways, but having them at our fingertips would certainly bridge that gap." The interaction between family physicians made possible by telemedicine networks could enhance network development and increase family physicians' ability to assist one another with diagnoses and treatments.

TIME SAVINGS

The time-saving potential of telemedicine has been promoted as one of its potential benefits, but some rural physicians said they were concerned that its use might actually increase demands on their time. One phone interview participant said that time away from patients would be a problem: "There's not time to be on the computers because we have to see a lot of patients in our practice." Another doctor thought telemedicine could only be used efficiently before or after office hours: "You can't take time away from seeing your other patients to be involved in any form of telecommunicating." The current study supports the conclusion by O'Neill et al. that "provider acceptance is usually related to the ease with which the telecommunications technology is integrated into the existing health care network and the ease of use of the technology."¹⁶

Surveyed physicians generally agreed that they would be interested in using telemedicine for continuing medical education. Significant amounts of time and money could be

saved on travel if physicians were able to participate in conferences or meetings via teleconferencing. One physician said it is difficult for him to spend five hours traveling round trip for a two-hour meeting. Additionally, some physicians and medical educators have proposed that CME credits be given for use of telemedicine consults.¹⁷

CONCLUSION

The results of this study indicate that rural family physicians in Minnesota possess a very limited awareness of telemedicine and issues associated with its use. Surveyed physicians were uncertain whether telemedicine will be effective, cost-effective, and reliable, whether it will meet patient and physician needs, or whether it will improve rural health care. It will be very difficult for rural practices, facilities, and patients to benefit from telemedicine when the key people in rural health care delivery—the physicians—do not yet have the knowledge necessary to make informed decisions regarding its use.

Many of the problems plaguing rural health care delivery may be partially addressed by telemedicine applications. Potentially, telemedicine may improve cost-effectiveness as well as such problems as professional isolation, lack of specialty access, long travel time, and inadequate CME opportunities. As telemedicine continues to be evaluated, cost-effectiveness needs to be determined; speculation is not sufficient.

Ultimately, the widespread implementation of telemedicine will be heavily dependent upon input from end-users. Vendors, administrators, and subspecialty physicians in tertiary care centers are not end-users.¹⁸ Those best suited to make decisions about medical care in rural communities are the health practitioners who provide that care. Knowledgeable, well-informed rural physicians are essential to guiding telemedicine's development.

The current study results have pertinence for everyone involved in telemedicine and/or rural health care. Suppliers and funders must make rural physicians aware of telemedicine's applications and how they may

benefit practicing physicians. Medical schools and residency programs should consider introducing telemedicine to students and residents. Finally, physicians must educate themselves on the use of telemedicine. We know the benefits and capabilities of the technology; the question that remains is whether health care providers will accept the technology. **MM**

Jon Kane and Jeff Morken are second-year medical students at the University of Minnesota–Duluth School of Medicine. Jim Boulger is an associate professor in the Family Medicine and Behavioral Sciences departments at the University of Minnesota–Duluth School of Medicine. Associate Professor Byron Crouse is head of the Family Medicine Department at the University of Minnesota–Duluth School of Medicine. Dale Bergeron is a program director at the Minnesota Center for Rural Health.

REFERENCES

1. Office of Technology Assessment. Health care in rural America [OTA-H-434]. Washington, D.C.: U.S. Congress, U.S. Government Printing Office, 1990. #052-003-0125-7.
2. Vanselow NA. Medical education and the rural health crisis: a personal perspective from experiences in five states. *Acad Med* 1990;65(Dec. suppl):527-31.
3. American Academy of Family Physicians. Draft policy statement: rural telemedicine. Washington, D.C.: American Academy of Family Physicians, 1994 July 14.
4. Rinde E, Nordrum I, Nymo BJ. Telemedicine in rural Norway. *World Health Forum* 1993;14:71-7.
5. Sanders JH, Tedesco FJ. Telemedicine: bringing medical care to isolated communities. *J Med Assoc Ga* 1993;82(5):237-41.
6. Is telemedicine the answer to rural health's problems? *Rural Health News* (Department of Family Medicine, University of Washington, Seattle) 1994;1(2):1,9-10.
7. Rural health care dials long distance. *State Rural Health Watch* 1994 March:2-4.
8. Higgins CA, Conrath DW, Dunn EV. Attitudes of health care providers toward slow-scan video. *Can Med Assoc J* 1982;127:225.
9. Fuchs M. Provider attitudes toward STARPAHC: a telemedicine project on the Papago Reservation. *Med Care* 1979;18(1):59-68.

10. Higgins CA, Conrath DW, Dunn EV. Provider acceptance of telemedicine systems in remote areas of Ontario. *J Fam Pract* 1984;18(2):285-9.

11. Grigsby J, Sanberg EJ, Kaehny MM, Kramer AM, Schlenker RE, Shaughnessy PW. Analysis of expansion of access to care through use of telemedicine and mobile health services: report 2: case studies and current status of telemedicine. Denver: Center for Health Policy Research, 1994.

12. Preston J. The telemedicine handbook: improving health care with interactive video. Austin, Texas: Telemedical Interactive Consultative Services, Inc., 1993.

13. Leonard J. Recommendations regarding the use of advanced telecommunications technologies to improve rural health education and health care delivery in Minnesota. St. Paul, Minnesota: Minnesota Department of Administration, Telecommunications Division, in cooperation with the Minnesota Department of Health, 1994 January 15.

14. Arthur D. Little, Inc. Can telecommunications help solve America's health care problems? [Executive summary.] Cambridge, Massachusetts: Arthur D. Little, Inc., 1992 July.

15. Randal T. Reaching rural: rural health travels the telecommunications highway. Rockville, Maryland: Federal Office of Rural Health Policy, 1994.

16. O'Neill JJ, Nocerino JT, Walcott P. Benefits and problems of seven exploratory telemedicine projects [Technical report MTR-6786]. McLean, Virginia: The Mitre Corp., 1975.

17. Mayo Symposium participants call for research on outcomes, costs. *Telemedicine* 1993;1(7):1,6-7.

18. Tangalos EG. Hearing on telemedicine: an information highway to save lives. Washington, D.C.: Subcommittee on Investigations and Oversight Committee on Science, Space and Technology, United States House of Representatives, 1994 May 2.

Join a medical group rich in support in an area rich in natural beauty

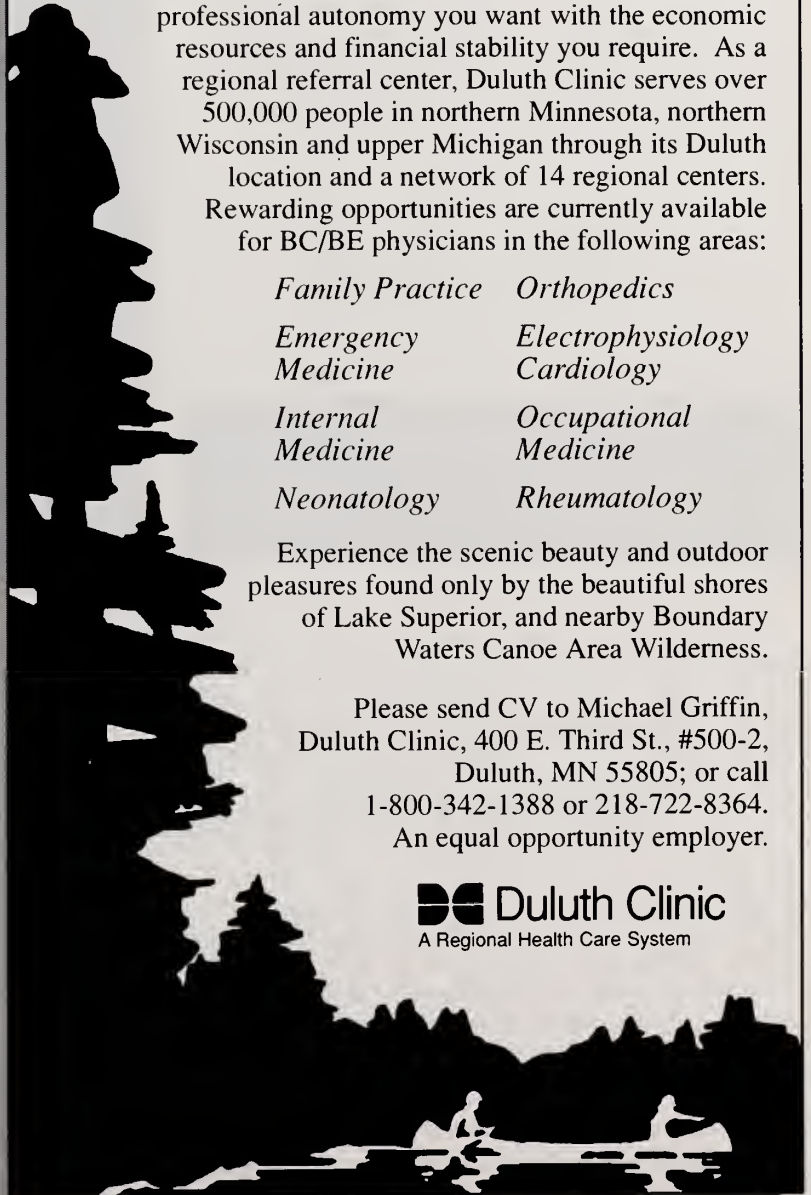
When you join Duluth Clinic, you become part of a 275-physician multispecialty group offering the professional autonomy you want with the economic resources and financial stability you require. As a regional referral center, Duluth Clinic serves over 500,000 people in northern Minnesota, northern Wisconsin and upper Michigan through its Duluth location and a network of 14 regional centers. Rewarding opportunities are currently available for BC/BE physicians in the following areas:

<i>Family Practice</i>	<i>Orthopedics</i>
<i>Emergency Medicine</i>	<i>Electrophysiology</i>
	<i>Cardiology</i>
<i>Internal Medicine</i>	<i>Occupational Medicine</i>
<i>Neonatology</i>	<i>Rheumatology</i>

Experience the scenic beauty and outdoor pleasures found only by the beautiful shores of Lake Superior, and nearby Boundary Waters Canoe Area Wilderness.

Please send CV to Michael Griffin, Duluth Clinic, 400 E. Third St., #500-2, Duluth, MN 55805; or call 1-800-342-1388 or 218-722-8364. An equal opportunity employer.

 **Duluth Clinic**
A Regional Health Care System



The Refreshment Committee Theatre Company Presents

FORGIVING TYPHOID MARY

BY MARK ST. GERMAIN

She cannot believe in a disease she carries but does not die from herself. Her doctors are trapped by the need to protect the public, Mary's right to freedom and their own integrity.

What is to be done and who will be responsible? The life of the infamous cook who contaminated New York in the early part of this century has vital importance today.

Discover the story of Mary Mallon –
the real "Typhoid Mary."

March 2-4 • 8-11 • 15-18

Wednesdays & Fridays at 8 pm • Saturdays at 3 & 8 pm

at The Minneapolis Theater Garage

Franklin & Lyndale Avenues in Minneapolis

TICKETS: (612) 227-0775

REGIONAL PREMIERE • 3 WEEKS ONLY

Postshow Forum • March 3
RIGHTS AND RESPONSIBILITIES:

The Dynamic Interface Between Individual and Public "Health"
– a discussion of bioethical issues raised by the play

STUTZMAN-HELLING COMPANY

Your Business & Tax Allysm

CONSULTANTS, ACCOUNTING AND TAX ADVISORS
APPRAISALS ARE OUR SPECIALTY
612-546-6375

Internal Medicine/Family Practice Spring Lake Park Medical Center

Become a member of Group Health, Inc. physician staff at our Spring Lake Park Medical Center. We have positions available for full time board certified/board eligible Internal Medicine/Family Practice physicians.

With a personable staff of primary care physicians, this clinic offers a solid patient base and reasonable call and hospital responsibilities.

Group Health, Inc., a progressive, managed care organization since 1957, is one of the largest multispecialty group practices in the Midwest. Group Health offers its physicians a balanced life-style, excellent salaries and a generous benefit package that includes paid malpractice.

If you are interested in starting a practice at the Spring Lake Medical Center, please call Ann Mliner, at (612)883-5337, 1-800-472-4695 or send CV to: Group Health, Inc. A division of HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

Group Health is part of the HealthPartners family of health plans. An EO/AA Employer.



HealthPartners

Health Care for the Uninsured in Duluth

Barbara Elliott, Ph.D., Colleen Renier, Laura Vecchi, and Terrence C. Clark, M.D.

ABSTRACT

Providing health care for Minnesota's uninsured population continues to be both a clinical and political challenge. Between October 1, 1991, and September 30, 1993, 1,260 previously uninsured people received charity health care in Duluth. No one was excluded because of pre-existing conditions. Their utilization of services and associated costs can help project the health care needs and costs of care for uninsured Minnesotans. This group of uninsured people used a different mix of health care services compared with insured Minnesotans, and their total costs (including prescriptions) were about 15% greater. A large proportion of these uninsured Minnesotans had chronic health conditions and a "pent-up need" for services and medications. This experience demonstrated that it is possible to administer a limited benefits plan in coordination with existing public and private resources.

In recent years the state Legislature and the Minnesota Health Care Commission have been working to provide universal access to appropriate health care for all Minnesotans. Legislation passed in 1994 mandates that Minnesota achieve universal coverage in 1997. Although the deadline may be delayed, accomplishing this goal at any time will require making difficult decisions about how the health care system will be structured and how the costs of care will be fairly shared.

The U.S. Congress was unable to agree on a health system reform plan, and it appears unlikely that a national solution will develop soon. Much of the United States is experiencing a rapid shift from a fee-for-service system to a managed care—often capitated—reimbursement system, meaning providers can no longer shift costs and continue to offer charity care. Another solution is needed. States need to address health care access issues and become laboratories for health system reform.¹ Many states have proposed ways to provide coverage for the health care needs of their citizens,² and Minnesota continues to be among them.

More than 400,000, or about 9%, of Minnesotans are uninsured—a smaller proportion of uninsured than in most other states.^{3,4} The subsidized insurance program, MinnesotaCare, attempts to address the needs of uninsured Minnesotans. Although the MinnesotaCare program currently insures 72,000 people, at least the same number of Minnesotans are uninsured now as before MinnesotaCare began enrolling participants in 1993.⁴ Recent national statistics indicate that five other states are doing a better job meeting this challenge than Minnesota.³

In order to make the necessary

decisions to meet the mandate of providing health care coverage for all Minnesotans, policymakers need to know more about the health care needs of uninsured Minnesotans and the costs of that care. Unfortunately, little factual information about these issues has been available. In addition to providing access to care, the project reported here was able to determine the health care services needed by uninsured people who received care in Duluth and to estimate the costs of this care, including the extent of any "pent-up need" in this population.

DESIGN

Between October 1, 1991, and September 30, 1993, health care was made available to the uninsured in Duluth through the Duluth Medical Center Health Care Program (DMCHCP).^{*} This demonstration project provided nearly \$2 million of donated and coordinated health care services to people who did not have health insurance and did not qualify for any public health insurance programs. Blue Cross and Blue Shield of Minnesota provided the administrative services and grant support that made evaluation of the project possible.

The benefits available to the DMCHCP enrollees resembled those

^{*}The services were donated by a consortia of Duluth providers, including Duluth Clinic, St. Mary's Medical Center, Miller-Dwan Medical Center, Polinsky Medical Rehabilitation Center, Anesthesia Associates, Arrowhead Pathologists, Duluth Clinic Pharmacies, Duluth Diabetes Center, Duluth MRI, Duluth Radiologists, Duluth Radiation Oncologists, and Midwest Medical Equipment Co. The BCBSM Foundation provided grant support for the project coordinator and for program evaluation, and BCBSM provided administrative services.

Table 1

Comparison of DMCHCP and MinnesotaCare benefits

Benefit	DMCHCP	MNCCare
Ambulance	X	X
Diagnostic, screening, and preventive services	X	X
Family planning	X	X
Immunizations	X	X
Inpatient hospital	X	X*
Medical equipment and supplies	X	X
Nurse practitioner	X	X
Outpatient laboratory and x-ray	X	X
Outpatient mental health	X*	X*
Chemical dependency	—	X*
Physical, occupational, speech therapies, and audiology	X	X
Physician and outpatient visits	X	X
Prescription drugs	(\$7 copay)	(\$3 copay, adults)
Rehabilitation therapy	X	X
Vision care	X*	X*
Maximum benefits:		
All care	\$10,000 (over 2 yrs.)	—
Outpatient	—	No limit
Inpatient	—	\$10,000/yr†

*Some limits apply.

†10% copay with maximum \$2,000 per person or \$3,000 per family per year.

of MinnesotaCare. Participants received essential health care services ranging from well-child care and vision exams to maternity and hospital care. Up to \$10,000 in services was available over two years to each eligible participant. Ten outpatient mental health visits were offered, but the program did not include chemical dependency or nursing home care. The copay for prescriptions was \$7. A comparison of the DMCHCP benefits and MinnesotaCare benefits is presented in Table 1. The full-time program coordinator for DMCHCP also counseled applicants regarding available public and private resources.

Analysis of this project was based on the information enrollees provided on a questionnaire about their health at enrollment and their utilization of services while participating. All DMCHCP enrollees were issued an identification card, which they presented to sponsoring providers when they needed health care. Providers reported rendered services to Blue Cross, where they were tabulated. Blue Cross summarized the services utilized by these enrollees and determined the value (costs) of the donated services using a standard insurance fee schedule. All services were donated; no payments were made to providers.

Blue Cross compared the uninsured enrollees' utilization and costs with those of approximately 27,000 people in northeast Minnesota who were insured during the same 24 months by a Blue Cross program that used the same fee schedule. The benefits packages were statistically adjusted so they were comparable.

PARTICIPANTS

To be eligible for DMCHCP, applicants had to be uninsured, unable to afford Minnesota Comprehensive Health Association (MCHA) coverage, and ineligible for public health insurance coverage. No one was excluded from DMCHCP because of a pre-existing (past or present) health condition. They needed to have been residents of the Duluth area for 12 or more months, be less than 65 years old, and have an income of 200% or less of the federal poverty level. The total enrollment at any time was lim-

Table 2

*Ages and gender of uninsured and insured groups**

Ages	DMCHCP (uninsured)		NE Minnesota (insured)	
	Males N (%)	Females N (%)	Males N (%)	Females N (%)
0-14 years	97 (18%)	72 (10%)	3,640 (28%)	3,360 (24%)
15-44 years	333 (62%)	434 (60%)	6,110 (47%)	7,280 (52%)
45-65 years	107 (20%)	217 (30%)	2,730 (21%)	2,940 (21%)
> 65 years	—	—	520 (4%)	420 (3%)
Total Enrollees	537 (43%)	723 (57%)	13,000† (48%)	14,000 (52%)

*See text. †Approximate.

ited to 1,000 participants, with 750 from Minnesota and 250 from Wisconsin. Because many enrollees became eligible for private insurance or for other programs, as enrollees left DMCHCP, new people were enrolled. A total of 1,260 people enrolled in the demonstration project over its two-year duration, including 947 Minnesotans and 313 Wisconsin residents. The average length of enrollment was 14 months.

Two-thirds of the program participants applied as individuals, while one-third applied as family units. Most (64%) lived alone or with one other person. Three-quarters of the enrollees had at least one person in the household who was gainfully employed, but insurance was available to the employed person in only 9% of these households. Few children enrolled in DMCHCP; parents were advised to enroll their children in Minnesota's Children's Health Plan, because it was less expensive for them at \$25 per child per year. Table 2 shows the gender and age distributions of the DMCHCP enrollees. Most participants were females, predominantly women over age 40; conversely, male enrollees were younger, with half of them under age 30.

To maintain their eligibility for the program, DMCHCP participants were asked to pay a monthly administrative fee ranging from \$5 to \$30 per month for individuals and \$5 to \$60 per month for families. Almost half of the participants paid \$5 per month, reflecting the fact that their incomes were 100% or less of the federal poverty level. The Wisconsin enrollees appeared to be more financially distressed than the Minnesota enrollees. The average enrollee from Wisconsin reported having assets of \$207 and living at 97% of the federal poverty level. The average Minnesota enrollee reported having \$1,000 in assets and living at 118% of the federal poverty level.

RESULTS

SERVICES UTILIZED AND COSTS INCURRED

There were no differences between the Minnesota and Wisconsin enroll-

	DMCHCP (Uninsured)	NE Minnesota (Insured)
Services/1000 members/year		
Hospital days	227	252
Hospital admits	58	61
Office visits	2,520	2,371
Emergency department visits	344	224
True emergencies	136	109
Other	208	115
X-rays	1,026	925
Laboratory	4,860	3,464
Surgeries	515	429
Rehab therapy	1,394	1,005
Prescriptions	4,500	1,350
Costs/member/month		
Inpatient services	\$18	\$24
Outpatient services	\$14	\$11
Physician services	\$23	\$21
Other professional services	\$22	\$20
Prescriptions	\$16	\$5
TOTAL	\$93	\$81

*Insured groups' benefits selected to match those of DMCHCP.

ees on any of the outcomes reported here. Consequently, the numbers are combined for this report.

As Table 3 indicates, total costs were 15% higher for the uninsured group compared with the insured Minnesotans. This difference resulted from the greater number of prescription drugs needed by the uninsured group. The costs of the medications added considerably to the uninsured group's total expense, which eclipses the fact that other costs were essentially equal.

DMCHCP enrollees used more outpatient services than the insured northeast Minnesota residents. The uninsured group used more office, laboratory, x-ray, and outpatient

surgery services than did the insured group (see Table 3). They also used emergency department (ED) services more often than insured northeast Minnesotans, and DMCHCP participants were more likely to use the ED in situations that were not true emergencies (using standard Blue Cross criteria for emergencies). On the other hand, insured northeast Minnesotans were hospitalized more often and had longer hospital stays. The higher costs of the hospital services for the insured group balanced the costs of the uninsured group's increased needs for outpatient services.

Many of the DMCHCP enrollees had been unable to obtain private insurance because of pre-existing

Table 4

Value of services provided to DMCHCP enrollees with and without chronic conditions

Costs/member/year	With chronic conditions	Without chronic conditions
Services	\$2,250	\$607
Prescriptions	\$420	\$115
TOTAL	\$2,670	\$722

Table 5

Estimated costs for the DMCHCP enrollees using a standard insurance fee schedule and MinnesotaCare schedule

Costs/member/year	Standard insurance fee schedule	MNCare fee schedule
Services	\$924	\$647
Prescriptions	\$187	\$191
TOTAL	\$1,111	\$838

conditions. Twenty-eight percent reported a pre-existing condition when they enrolled, and an additional 19% of the enrollees were diagnosed with chronic conditions while being served by DMCHCP. Forty-seven percent of the DMCHCP enrollees required and received treatment for pre-existing conditions and chronic illness. The enrollees with pre-existing and chronic conditions accounted for approximately 75% of the utilization and costs incurred by this group (see Table 4). The chronic diseases identified in this population included arthritis, cardiovascular disease, diabetes, hypertension, lung diseases, and mental disorders. Information about the proportion of the insured group with chronic conditions was not available. The uninsured group needed and used more services in the management of chronic conditions than did the insured group.

The uninsured group also needed many more prescription medicines than the insured comparison group.

In fact, they filled about three times as many prescriptions per member, and the costs were also about three times greater (see Table 3). The greater prevalence of pre-existing and newly diagnosed chronic conditions that could be managed with drug therapies in the uninsured group explains this difference (see Table 4).

The maximum value of donated services available for each DMCHCP enrollee was \$10,000 over two years. Some participants reported avoiding preventive and primary care to keep their \$10,000 available to treat illness when it occurred. Thirty-five individuals (only 2.8% of the participants) exceeded this limit, but their costs and use of services above \$10,000 could not be measured.

COST COMPARISONS WITH MINNESOTACARE

The financial information available from this demonstration project allows us to estimate how much the health care provided to this unin-

sured population would have cost using the MinnesotaCare reimbursement fee schedule (see Table 5). MinnesotaCare uses the Medicaid fee schedule and reimburses approximately 55% of the amount providers bill for services (approximating physicians' overhead). On the other hand, the value of the services provided in this program were based upon a standard insurance fee schedule at about 75% of the usual billed amount. Table 5 shows the health care costs of the DMCHCP group using the standard insurance fee schedule compared with their costs using the MinnesotaCare fee schedule. The health care services costs of the uninsured person totaled \$924; this converts to \$647 using the MinnesotaCare schedule.

The \$647 total does not include prescription drug costs, which are figured separately. Using the MinnesotaCare formula, the prescription drug costs for each DMCHCP member would have been \$191 per year. Paying for both the health care services and the prescriptions for this uninsured population would have cost the MinnesotaCare program \$838 per member per year.

DISCUSSION

The cost of providing care for this group of uninsured Minnesotans was essentially the same as providing care for the insured Minnesotans until prescription medications for the uninsured were added to the total. Although the uninsured group used more services, they used less expensive outpatient services; the insured group had more hospital admissions and longer stays, which were more expensive. The cost and access to medications for uninsured Minnesotans need to be included in discussions about how universal health coverage will be designed and funded.

Enrollees in the DMCHCP demonstration project did not differ from other uninsured Minnesotans.^{5,6} The distribution of enrollees by age and gender (Table 2) revealed that young males and older females enrolled in the program disproportionately compared with the insured group. The women had lost health insurance because of divorce, separation, or

death of their spouses, while younger men and women were the working poor or their family members. These demographics describe the people who are among the 12% of non-elderly Minnesotans who are still without health care coverage.

The uninsured in Minnesota are also people who have been refused health insurance because of pre-existing health conditions. Although these people would be eligible for coverage through MCHA, anyone at or below 200% of the federal poverty level could not afford the premium. The proportion of DMCHCP enrollees admitting to pre-existing conditions (28%) is the same as the percentage who claimed to have pre-existing conditions in the Health Insurance Project.⁶ However, health care utilization information included in DMCHCP records revealed that nearly half of the uninsured enrollees (47%) needed care for chronic conditions. These enrollees used more than three times as many services, compared with the other DMCHCP participants. In order for any reimbursement scheme to adequately finance the health care required by a group with chronic health care needs, an even larger number of healthy subscribers is needed. All potential participants must be enrolled and pay premiums in order for the available funds to sufficiently cover the costs of the health services utilized by the entire group.

The cost of programs to meet the health needs of Minnesota's uninsured citizens will also depend on which benefits are included in any minimum benefits package. Mental illness services, including chemical dependency care, are often limited or even eliminated from benefits packages in order to control costs. Potentially, decisions regarding benefits packages may discriminate against groups of people with certain health conditions; such decisions may be tested in the courts based upon the Americans with Disabilities Act. On the other hand, broadening benefits packages challenges cost containment.

Not only does the basic benefits package affect the well-being of Minnesota citizens, but it also has implications for the welfare system.

When individuals' health care benefits are limited (especially for people with chronic conditions), their functional ability may be compromised to an extent that they can no longer be employed. For instance, without arthritis medications, insulin, antidepressants, or rehabilitation services, some people are unable to work, and they become dependent on the social safety net. Welfare reform, currently on the legislative agenda, needs to be crafted hand in hand with health reform.

SUMMARY

The following conclusions can be drawn from this study. They provide some of the information necessary to decide how Minnesota can best achieve universal health coverage for its citizens.

1. The participating group of uninsured Minnesotans used a different mix of health care services compared with insured Minnesotans, and their total costs (including prescriptions) were about 15% greater.

2. A large proportion of these uninsured Minnesotans had chronic health conditions resulting in a "pent-up need" for services and medications.

3. Information from DMCHCP may be helpful in projecting health care costs for uninsured Minnesotans (adjusting for enrollment factors, benefits packages, and reimbursement formulas).

4. Paying the costs associated with universal coverage cannot be achieved fairly unless universal participation is also accomplished.

5. This experience shows that it is possible to administer a limited benefits plan in coordination with existing public and private resources. **MM**

ACKNOWLEDGMENT

The authors wish to thank Deborah Glass and Gail Nelson at Blue Cross and Blue Shield of Minnesota for helping to make this project possible.

Barbara Elliott is a faculty member in the Department of Behavioral Sciences at the University of Minnesota-Duluth School of Medicine. Colleen Renier is a statistician in the Department of Behavioral Sciences

at the University of Minnesota-Duluth School of Medicine. Laura Vecchi is a research assistant at Duluth Clinic and was the program coordinator of DMCHCP. Terrence Clark is a pulmonologist and medical director of health plans at Duluth Clinic.

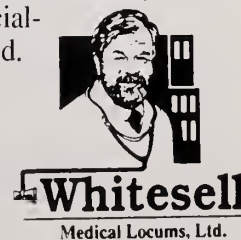
REFERENCES

1. Elliott BA. State 'laboratories' test health care reform solutions. *Minn Med* 1993; 76(2):14-21.
2. 1994 state legislative survey. *Health Systems Review* 1994;27(5):28-51.
3. Nonelderly population without health insurance by state, 1988-1993 [Table 3]. In: EBRI databook on employee benefits. Washington, D.C.: EBRI, January 1995.
4. Preliminary estimates of the numbers of uninsured Minnesotans: staff report to the Minnesota Health Care Commission. Minneapolis: Minnesota Health Care Commission, 1994 October 4.
5. General Accounting Office. Health insurance coverage: a profile of the uninsured in selected states. Washington, D.C.: GAO, 1991.
6. Arrowhead Regional Development Commission. Ensuring access to health care in NE Minnesota. Duluth, Minnesota: ARDC, 1994.

MINNESOTA LICENSED LOCUM TENENS PHYSICIANS AVAILABLE!

For hassle-free help to cover for vacations or absences from your practice, call today. All major specialties covered.

Medical review officers now on staff.



Whitesell Medical Locums, Ltd.

Eight First Ave. S.

Buffalo, MN 55313

Phone: 800/876-7171

FRANZ

(continued from page 7)

talks with Mayo Clinic about providing their tribe with basic health care services at their Community Center. Thomas Harman, M.D., chair of Mayo's Department of Family Medicine, called on Franz to set up the project. "Walt was a natural because of his interest in working with patients who are disadvantaged because of their location or social or economic circumstances. He makes an active attempt to understand cultural differences," says Harman.

Unlike the free care provided at Blooming Prairie, Mayo and Prairie Island have a fee-for-service agreement. However, Franz describes the relationship between the Prairie Island Dakota Community and Mayo as much more than a business arrangement. It's based not only on a contract, but on deeply held spiritual beliefs, as well. Two years ago, one of the Prairie Island families brought their critically ill son to Mayo. Doctors could not save him. The family presented Mayo with a sacred peace pipe in hopes that it would help Mayo better understand Native American culture, and this would then help the family heal. "The family believes that this new relationship with Mayo is a natural consequence of the sacred peace pipe gift," says Franz. And whenever Franz and his staff get bogged down in the details of organizing this health care service, they remind one another, "Let's focus on the pipe."

Franz travels to Prairie Island once a week. Wendy Bartanen, M.D., covers a second day. "Walt has been a role model for me," says Bartanen, a family practice specialist based at Mayo's Regional Practice in Wabasha. As a former student and resident, and now a colleague of Franz's, Bartanen is following in her mentor's footsteps. "He's always quick to volunteer. His priority of providing community service and working with underserved populations inspires me."

Medical students, residents, and nurse practitioners-in-training also work with Franz at Prairie Island.

Together, they strive to meet the ongoing basic health care needs of the Prairie Island Community and provide access to more specialized services at Mayo when appropriate. They emphasize patient education and may help collect data for Mayo's research studies. "Community members are especially interested in preventive medicine, women's health care issues and studies, and information pertaining to chronic disease, chemical dependency, and diabetes," says Franz. A family medicine physician is always available to answer emergency medical questions over the telephone. Mayo also provides free medical services during community events, such as Pow Wows.

The Prairie Island Dakota Community is looking into building a new medical facility to serve patients on the reservation. Franz hopes they will build a clinic with necessary medical equipment, as well as a conference center with telecommunications capabilities and an area to consult with healers from the Native American

community. "Now's the perfect time to be setting up alliances such as these," says Franz. "They are cost-efficient because you're seeing patients in their own community."

Away from the job, Franz enjoys running and collecting historical medical trivia. He and his wife, Dinah, have two children—Shannon, a ninth-grader, and Ryan, a fifth-grader. Two dogs, two cats, and a rabbit round out their busy household. Dinah is part of a professional jazz/pop vocal quartet called Sentimental Journey. Franz has traded in his soccer uniform, shoes, and coach's gear to sit in the stands and cheer on Shannon as she carries on the family's soccer tradition.

"Medicine is not a career for me," says Franz. "It's a lifestyle. The future of medicine is right here—caring for patients who are underserved. I'm not going to worry about health care reform."

MM

Rebecca Gonzalez-Campoy is a freelance writer living in Shoreview.




**MEDICAL
 COLLEGE
 OF WISCONSIN**

CME
program

Department of
 Psychiatry and
 Behavioral Medicine

NINTH ANNUAL

THE DOOR COUNTY SUMMER INSTITUTE

Landmark Resort, Egg Harbor, Wisconsin
 Sessions run 9:00 am-12:15 pm daily
 CME and CEU credits available

July 24-28, 1995

Session I Philip Janicak, MD

"The Rational Use of
 Psychopharmacotherapy"
 "Brief Versus Long
 Psychotherapy"

Session II James P. Gustafson, MD

July 31-August 4, 1995

Session III Alan J. Ravitz, MD

"Brief Psychotherapy
 With Children and
 Adolescents"
 "A Relational Model of
 Women's Development:
 Theory and Clinical
 Applications"

Session IV Judith Jordan, PhD

Session V Robyn S. Shapiro, JD

Arthur R. Derse, MD, JD

"Bioethics in the Age
 of Managed Care"

August 7-11, 1995

Session VI Donald Melchenbaum, PhD

"Post Traumatic Stress
 Disorder (PTSD) in
 Adults and Children"

Session VII Peter L. Brill, MD

Len Sperry, MD, PhD

"Corporate Therapy
 and Consulting"

Session VIII L. Cass Terry, MD, PhD,

Rose M. Dotson, MD,

Safwan Jaradeh, MD,

Eric F. Maas, MD and

George L. Morris, III, MD

"Neurology for
 Non-Neurologists"

For more information, please contact:

Carl Chan, MD, Medical College of Wisconsin, 8701 Watertown Plank
 Road, Milwaukee, WI 53226 (414) 257-5995.

EAST METRO *Community Health* NETWORK

Physician Family Medicine

The East Metro Community Health Network is seeking a BC/BE family medicine physician with an interest in community-based health care. The ideal candidate will have an interest in working with low-income/minority populations. Must be licensed to practice in Minnesota. Attractive hours, salary, benefits. No call. Full and part-time positions available. Interested applicants send CVs to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

St. Croix Falls Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

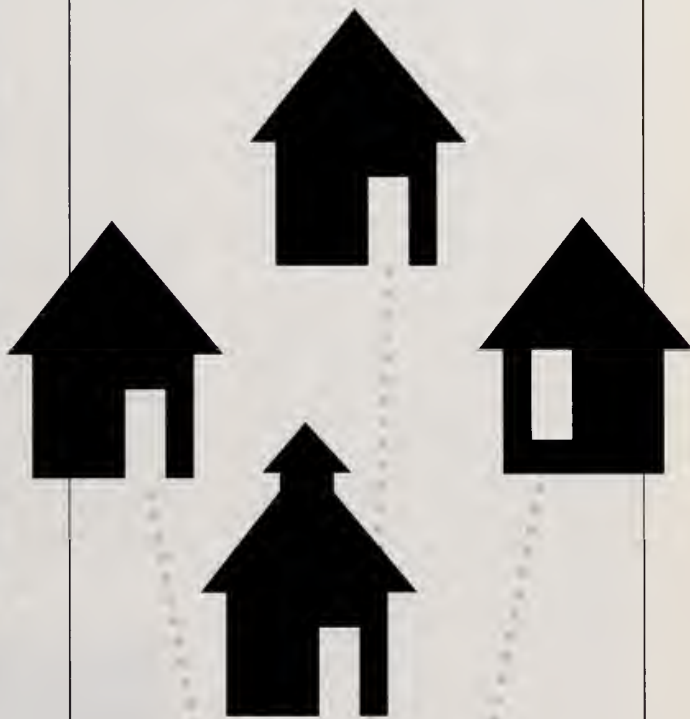
We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detail CV to:

Cathy Kortas
River Valley Medical Center
208 S. Adams Street
St. Croix Falls, WI 54024
(715) 483-3221

Children on ventilators...

When young people need this complex form of care, there's a place with experience and successful outcomes.



Since 1988, we have provided comprehensive inpatient and outpatient medical, rehabilitative and habilitative care to infants, children and adolescents who require a ventilator or have an airway obstruction. Medical conditions include:

- spinal muscle atrophy
- muscular dystrophy or polio
- spinal cord injury or anomaly
- central breathing dysfunction
- premature infants with bronchial-pulmonary dysplasia or chronic lung disease

Our goal is to return these young people to their home and community.

To refer a patient to the TDR program at Gillette Children's Hospital, call **(612) 229-3954**.

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

DETECTIVE

(continued from page 9)

would have records. Mr. Rog would investigate.

The caretaker from Mrs. Lere's apartment called but did not know Ivona and Michael; they had never lived there. The apartment was listed to a Mr. Allemand, who had rented it two years ago. He had made a large deposit from which the landlord withdrew monthly rent. Several months after renting the unit, Allemand made another large deposit and said he was going back to Europe; he would send more money later. Mr. Allemand only collected mail there.

A quick review of Michael's medical chart gave me his religion: Roman Catholic. I called the St. Paul Cathedral; I was merely referred to local churches, which had no information. Perhaps the French Catholic church in Minneapolis? No, Our Lady of Lourdes had never heard of the family. Holy Cross, a Polish Catholic church, told me they had never heard of the family either, and informed me that Brat is not a Polish name.

On to the French community. The French Cultural Institute didn't understand what I was trying to accomplish. The French Consulate in Minneapolis is only honorary. Another dead end.

I called Bonnie, the barkeep at the Spaniel Bar, to ask if she had remembered anything. "No!" she answered curtly, reminding me that she had my number.

I called the Polish Consulate in Chicago, which referred me to the embassy. Nothing.

The next day, the phone rang. The caller introduced himself as Andrew Kemper—"but people call me Jerry," he said. "Bonnie gave me your number. I know Monika; in fact, I was her American 'adoptive' father."

Naturally, my first question was, "Who's *Monika*?" But I should have known—remember Ivona's middle initial is "M"? Ivona *Monika* Brat. She went by Monika.

The conversation further revealed that the patient's father was Anthony Allemand, a French ballet dancer who

had been murdered in the Twin Cities just over a year ago. Tony, as he was known, was a heavy drinker. At a party in St. Paul, he was given a vodka and orange juice heavily laced with arsenic. When Tony arrived at the emergency room, the physicians thought he was drunk. It was too late.

Monika returned to Poland immediately after Tony's death.

Jerry had a friend who recently visited Monika while in Europe. Monika had returned to Poland to be with Michael, but had later moved to Sweden, where Jerry's friend met her. Jerry said he would call his friend for information. He did. Monika was back in Poland.

I telephoned Chester Rog, who said he would be happy to translate and type letters, if necessary. In the meantime, Jerry called me with Monika's telephone number. Donna

from the study office contacted Monika and arranged for a follow-up examination.

I closed the file. Mission accomplished. MM

Acknowledgment

The author thanks Donna Irlbeck and Dr. C. Gail Summers for their support and encouragement, Alice J. Schmidt for editorial assistance, and Timothy J. Sachi for technical assistance.

P. Michael Nordberg is currently the administrator for Spine Surgeons of Minnesota, P.A., in Minneapolis. He has more than 20 years' experience in accounts receivable management. During these years he has developed and refined techniques necessary to locate patients. Since 1991 he has lectured and published on related subjects.

North Central Medical Conference

Presents Two Exciting Tours From Minneapolis/St. Paul



SWITZERLAND & GERMANY

September 8-16, 1995

\$995.00

Per person, double occupancy.
(Plus \$34.00 taxes.)

We invite you to experience the splendor of the Swiss Alps and a chance to sample the famous "Black Forest Gateau!"



IRELAND

September 29-October 7, 1995

\$995.00

Per person, double occupancy.
(Plus \$37.00 taxes.)

Welcome to Ireland. Visit Galway, Blarney, Dublin, and other interesting cities and towns. A hundred thousand welcomes await you!

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.

For additional information and a color brochure contact:

GLOBAL HOLIDAYS

9725 Garfield Avenue South, Minneapolis, MN 55420-4240

(612) 948-8322 Toll Free: 1-800-842-9023

ANNOUNCEMENTS

• • • • •

ATTEND DAY AT THE CAPITOL

Don't miss the Minnesota Medical Association/MMA Alliance Day at the Capitol on Thursday, March 30. Festivities will begin at noon with lunch at the Kelly Inn in St. Paul. Invited guest speakers are Gov. Arne Carlson and the chief authors of the MMA Quality & Coverage bill, Sen. Sheila Kiscaden, IR-Rochester, and Rep. Thomas Huntley, DFL-Duluth. The cost for this event, including lunch, is \$16. To register and/or to schedule an individual visit with your legislator, call Wendy O'Donnell, 612/378-1875 or 800/999-1875. The deadline for registration is March 24.

• • •

BILL DEADLINES

House Speaker Irv Anderson, DFL-International Falls, has announced this session's deadlines. By March 31, all bills must be passed out of policy committees in one house. By April 7, all bills must be passed out of policy committees in the other chamber. By April 21, omnibus appropriations bills must be approved by policy committees.

• • •

GROWTH LIMIT IS 8.2 PERCENT

The Minnesota Department of Health has announced that the actual limit on the growth of health care expenditures in 1995 is 8.2 percent. This is a change from the estimated growth rate of 8.3 percent. The announcement was published in the January 30 *State Register*. The growth limit in 1994 was 9.4 percent.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Quality & Coverage Bill Heard in House Committee

The MMA Quality and Coverage bill received a preliminary hearing in the House Health and Human Services Committee February 9. Timothy Crimmins, M.D., chair of the MMA Board of Trustees, told committee members that the regulated all-payer option (RAPO) with its fee limits and volume controls threatens Minnesota's high-quality health care. A key feature of the MMA bill is a call for repeal of RAPO, which would set price and volume controls in the fee-for-service market. Crimmins, an emergency physician at Hennepin County Medical Center, said, "We see everyone who comes into the emergency room. We don't control the volume. Under RAPO, we would be punished for doing what's right." In contrast to RAPO, which would force people into a few large integrated service networks (ISNs), "the MMA model would allow many different health plans to compete without allowing them to exclude the sick or cherry-pick the healthy," Crimmins said.

Following Crimmins' testimony, chief House author, Rep. Thomas Huntley, DFL-Duluth, walked the committee through the bill section by section. The key features of the MMA bill are a call for repeal of RAPO, sunset of the 2 percent tax on health care services, cigarette tax increases to fund the MinnesotaCare program, an income tax penalty for failure to buy insurance, modification of community rating to permit lower rates for young people, seat-belt and helmet laws, professional

liability reform, uniform regulations for all health plans, data privacy protections, clarification of responsibilities for data collection, and repeal of state practice parameters.

Huntley summarized regulations, which would hold health plans accountable for providing quality and access. One such provision would prevent health plans from designing networks that exclude high-risk patients. "Currently, a plan could design a network that had no AIDS specialist," Huntley said. "Obviously this would give it an economic advantage over networks with physicians who specialize in treating this very expensive disease."

The MMA bill also calls for professional liability reforms. "We want to put limits on the 'deep pockets' theory of liability," Huntley said. "Currently, if someone has minimum liability, but lots of money, they may end up paying the whole bill." Among the MMA bill's professional liability provisions are reform of joint and several liability laws and limits on non-economic damages, such as pain and suffering.

During a brief question and answer session following Huntley's summary of the bill, Rep. Roger Cooper, DFL-Bird Island, asked why the MMA bill calls for repeal of practice parameters. Crimmins explained that the Practice Parameter Advisory Committee tried to develop state practice parameters, but found too many exceptions for patients in unique circumstances. "Developing practice parameters requires

Q&C continued on page 35



Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

Can the Physician-Patient Relationship Survive?

Managed care offers opportunities to provide well-coordinated, efficient health care. But in an increasingly competitive marketplace, it also has the potential to create conflicts of interest that strike at the heart of the physician-patient relationship.

The physician-patient relationship is important; our patients trust us enough to follow our instructions, confide private information, and sometimes even put their lives in our hands. They know we are in their corner—we have taken an oath to put their welfare above our own and to act as their advocate.

This oath of altruism—a bedrock of our profession—may be put to the test by some managed care techniques that create a potential conflict of interest between us and our patients. Plans may offer financial incentives to limit diagnostic tests, referrals to specialists, hospital care, or other services by providing bonuses based on expenditures or by withholding a percentage of reimbursement to cover shortfalls. These incentives are not inherently unethical, but they raise concerns. More alarming, plans may “de-select” physicians who order too many expensive tests or procedures. Explicit or implicit policies can put pressure on physicians to cut corners.

These ethical issues in managed care are examined in a report by the

AMA Council on Ethical and Judicial Affairs, which was summarized in the January 25 *JAMA*. The report offers some guidelines to help us steer a safe course through rough waters.

The AMA council reaffirmed that, without regard to any financial incentives, the patient’s welfare must remain our first concern. We have an ethical responsibility to tell our patient all treatment alternatives regardless of cost and regardless of whether they are covered by insurance. We must also disclose any financial incentives or contractual restrictions that might affect patient care. In some cases, we may be obliged to appeal on behalf of a patient who is denied coverage. Our first loyalty must be to the patient, not to the health plan.

“Financial incentives are permissible only if they promote cost-effective delivery not the withholding of necessary care,” according to the council. Its report recommends ways to help ensure that managed care techniques don’t cross over the line:

- Base financial incentives on the performance of a large group rather than individual physicians.
- Make payments on a yearly rather than monthly basis so there is more opportunity to balance out a month in which some patients need unusually expensive care.
- Set reasonable limits on how much ordering tests or services can affect the physician’s income.

Conflict of interest is the most serious threat to the physician-patient relationship, but managed care may erode other aspects of the relationship, as well. Another article in the January issue of *JAMA*, “Preserving the Physician-Patient Relationship in the Era of Managed Care,” defines the key components of the physician-patient relationship as the six C’s—choice, competence, communication, compassion, and continuity, as well as (no) conflict of interest—and describes how each C may be undermined by managed care.

Managed care plans limit choice of physician and access to specialists and to certain procedures.

Competence may be compromised if health plans apply pressure on primary care physicians to continue to manage conditions that should be referred to specialists.

Communication and compassion may be undermined by pressure on physicians to see too many patients in too short a time and to spend too much time on administrative duties and too little time explaining.

Continuity of care may be disrupted in a number of ways. In a competitive market, employers may switch plans from year to year, forcing workers to change physicians. Employees who change jobs may also have to change doctors if their doctor isn’t in the new employer’s health plan network.

In this managed care environment, how can we maintain our relationship with our patients and preserve the ethical principles of our profession? One way is to take part in health plan policy development. Another way is to promote legislation to protect choice and to require full disclosure to patients about incentives to limit care or referrals. Such concepts are included in the MMA’s Quality and Coverage Act.

Managed care techniques can improve quality of care, but only if they are implemented in a way that preserves the physician-patient relationship and allows us to maintain the altruistic principles of our profession.

• • • • •

Q&C continued from page 33

a great deal of research, costs hundreds of thousands of dollars, and they're almost out of date before they are finished." He said the committee concluded that state practice parameters would not work and voted itself out of existence. Huntley added that practice parameters are being developed at the federal level at a cost of about \$750,000 apiece for the simplest ones. He questioned whether the federal guidelines would apply in Hennepin County, or Bird Island, or Duluth.

There were some indications of controversy. Kris Hasscamp, DFL-Crosby, said, "If I learned a lesson from last year's election, it's that people don't want any more government intrusion into their life. I have a real problem with making people criminals for not wearing helmets." Huntley said he believed that the Minnesota United Snowmobilers Association supports the helmet law, but Hasscamp suggested that might be just because snowmobilers would freeze to death without one. The Minnesota Motorcycle Association is expected to vigorously oppose the helmet law.

In answer to questions about whether the cigarette tax will really raise enough money to fund MinnesotaCare, Crimmins said that the Minnesota Health Care Commission estimates that \$120 million will be raised the first year. This estimate adjusts for an anticipated decrease in smoking. The tax hike is expected to cause a dramatic drop in teenage smoking.

Immediately following the hearing of the MMA bill, the committee heard testimony from Rep. H. Todd Van Dellen, IR-Plymouth, on the IR health care bill, H.F. 255. Action now moves to the MinnesotaCare Division, where the real debate will take place.

• • • • •

IR Bill Would Repeal RAPO and Universal Coverage Mandate

In presenting the IR bill, H.F. 255, to the House Health and Human Services Committee, chief House author, Rep. H. Todd Van Dellen, IR-Plymouth, said, "People are concerned about the large health plan mergers, and rules designed to push all Minnesotans into 'one-size-fits-all health care.'" Like the MMA bill, the IR bill would repeal RAPO, create a competitive marketplace, authorize medical savings accounts (MSAs), and reform professional liability law. Unlike the MMA bill, it would repeal the universal coverage mandate, repeal insurance reforms, and repeal growth limits. The IR bill would retain the 2 percent tax on health care services and would not raise the cigarette tax. It does not include public safety measures or provisions to make health plans accountable for providing quality and access.

"It is unrealistic to pursue universal coverage without federal health care reform," Van Dellen said. "There would be an influx of non-residents into the state, and it would be too costly."

He called MSAs a "powerful new instrument to cover the uninsured," one that will offer greater choice and competition in the marketplace. MSAs are expected to appeal primarily to young, healthy, single people with incomes above 200 percent of the federal poverty level. MMA member Kenneth Heithoff, M.D., testified in favor of MSAs. "The current system is a disaster," Heithoff said. "We are losing our freedom to be patient advocates." He said that MSAs would make patients the "gatekeepers" by putting them in charge of their health care dollars and giving them a choice of providers.

Among those speaking in support of the IR bill were Nancy Hilden, director of health policy for the Minnesota Chamber of Commerce, and

James Ulland, director of the Minnesota Department of Commerce. "MinnesotaCare legislation is driving insurers out of the market," Ulland charged. He cited the exit of the American Family Insurance Company in December, which left thousands of Minnesotans without insurance. In a letter to the Department of Commerce, American Family, which offered indemnity insurance to individuals primarily in rural areas, said this was the first time the company had ever abandoned a market. It listed the reasons as: RAPO, inability to form a for-profit ISN, the ban on exclusive contracts, community rating, and guaranteed issue.

"Both the MMA and the IR bills suggest we need to make substantial changes in MinnesotaCare," Ulland said. "RAPO will not work; price controls have never worked." He said he anticipates a "huge revolt against universal coverage." Ulland supports the IR provisions that would allow exclusive contracts, repeal further compression of insurance rating bands, and repeal guaranteed issue. "Guaranteed issuance will only work if there is universal coverage, a concept the Legislature should reject," he said.

Chair of the House Health and Human Services Committee, Bob Anderson, DFL-Ottertail, referred both the MMA and IR bills to the MinnesotaCare Division of House and Human Services, chaired by Cooper, which is expected to put together the health system reform bill that will move forward in the House. "The next time you see provisions from these two bills they will be included in Rep. Cooper's bill," said Anderson. The Legislative Oversight Commission is also drafting a bill, which is expected to be referred to the MinnesotaCare Division.

• • • • •

MINNESOTA CARE NEWS

RAPO Is ON THE ROPES

Momentum is building against implementing RAPO. Not only do the MMA and IR bills call for repeal, but the RAPO Advisory Committee, convened by the Minnesota Department of Health to make recommendations about the implementation of RAPO, has recommended that the RAPO fee schedule be repealed.

According to the committee report, there isn't adequate data to develop either a Minnesota-specific DRG system or a Minnesota-specific RBRVS system. The committee believes that the risks of implementing an untested reimbursement system are too great and the effort should be abandoned. The committee noted that the health care market has changed since legislators approved the RAPO concept. Inflation has been lower than expected and the population that would be affected by RAPO is now very small. Bruce Cunningham, D.O., represents the MMA on the 35-member committee, which includes providers, payers, and consumers.

In his fiscal year 1996-97 budget initiative, Gov. Arne Carlson recommends that the development of the RAPO fee schedule be "suspended" but activities to monitor the cost of delivering services outside the integrated service network system be continued. Rather than repeal the RAPO fee schedule legislation, the governor wants to keep it on the books in case the fee-for-service market's growth rate exceeds the state growth limits. Minneapolis DFLers Sen. Linda Berglin and Rep. Lee Greenfield, key members of the Legislative Oversight Commission (LOC), also favor delay rather than repeal.

LOC MAY REJECT CIGARETTE TAX

A cigarette tax increase won't be included in the Legislative Oversight Commission (LOC) bill, predicted

Tom Swain, chair of the Minnesota Health Care Commission. He told commission members he heard this information from "someone who should know." MMA lobbyists expect the LOC bill to call for a delay of RAPO.

Although rumors occasionally leak out, the LOC bill is being developed behind closed doors by a bipartisan group that includes Sens. Linda Berglin, DFL-Minneapolis, Sheila Kiscaden, IR-Rochester, Edward Oliver, IR-Deephaven, Pat Piper, DFL-Austin, and Dallas Sams, DFL-Staples, and by Reps. Lee Greenfield, DFL-Minneapolis, Becky Lourey, DFL-Kerrick, Peggy Leppik, IR-Golden Valley, and Roger Cooper, DFL-Bird Island. There is one vacancy to be filled by an IR House member.

For the past two years, the LOC bill, sponsored by Berglin and Greenfield, has been the only viable MinnesotaCare bill. This year, Berglin and Greenfield will still be key players in the debate, but the LOC bill's future is not certain since the MMA and IR bills are on the table.

RISK ADJUSTMENT REPORT ISSUED

The departments of commerce and health have issued a joint report calling for a mandatory risk-adjustment system for all health plans except self-insured companies to be implemented by July 1, 1997. The state does not plan to introduce its own bill this session but expects its risk-adjustment ideas to show up in other group's legislation, such as the bipartisan Legislative Oversight Commission bill.

Risk adjustment will be necessary if the state sticks to its plan to achieve community rating by 1997. If rating restrictions don't allow companies to base their premium prices on risk factors, there has to be a way to make sure health plans with sicker

enrollees receive more money. Even without community rating, risk adjustment will be important to reduce incentives for health plans to avoid high-risk populations, according to this report.

The report calls for a risk-adjustment system to be funded with an assessment on health plan companies beginning in 1997. The risk-adjustment mechanism would not intervene in financial arrangements between health plan companies and providers.

HTAC RELEASES STEREOTACTIC RADIOSURGERY STUDY

Lack of adequate data hampered the Health Technology Advisory Committee (HTAC) in its most recent study. But in general, HTAC found neurosurgery to be preferable to stereotactic radiosurgery (SRS) in treating brain tumors. According to a draft report recently released by HTAC, when conventional surgery is contraindicated because of the lesion's location or patient preference, or when conventional therapy has failed, radiosurgery is a "reasonably safe and effective treatment for the treatment of arteriovenous malformations, metastatic brain tumors, and benign and primary malignant brain tumors." The report notes that a review of the safety and effectiveness of SRS performed by both gamma knife and LINAC systems is limited by the lack of controlled clinical studies. Because of lack of valid data, it was not possible for HTAC to judge whether gamma knife or LINAC systems worked best for various clinical applications, or to compare their cost-effectiveness. Nor was HTAC able to evaluate the cost-effectiveness of SRS vs. conventional therapy. Noting that stereotactic radiosurgery is rapidly evolving and clinical trials are underway, HTAC recommends that this technology be reassessed when new

MINNESOTA CARE NEWS

data becomes available. The report recommends that any plans to add a stereotactic radiosurgery system in Minnesota in the next five years should be reviewed within the context of current equipment capacity, capital, operating costs, and professional requirements. If you wish to read the entire report, contact Mary Fahey at 612/282-6355.

• • • • •

HTAC RECOMMENDS AGAINST WIDESPREAD PSA SCREENING

The Health Technology Advisory

Committee has issued a draft report recommending against using prostate specific antigen (PSA) as a routine screening test for prostate cancer in men with no symptoms of disease. The report found that the benefits don't outweigh the significant financial costs and the negative impact on quality of life caused by aggressive treatment of prostate cancer through radiation or surgery. HTAC concluded that the detection of prostate cancer through routine screening may trigger a "cascade of care," the effectiveness of which is questionable. The effectiveness of

various treatment options such as watchful waiting, radical prostatectomy, and radiation therapy for early-stage prostate cancer has not been established. Studies have shown that selected groups of men with untreated, localized prostate cancer have age-adjusted survival rates that are similar to those of men without the disease. It is difficult to distinguish between men with latent, medically unimportant cancer and those with the active disease. To obtain a copy of the report, contact Mary Fahey at 612/282-6355.

Why Raise the Tobacco Tax to Fund MinnesotaCare?

• • • • • THE TAX INITIATIVE FOR A Healthy Minnesota, a group of organizations that includes the MMA, is strongly supporting a cigarette tax increase this legislative session. The coalition has compiled the following reasons to support the tax hike.

Prevent Teen Smoking

- Most smokers start by age 15 and are addicted by 18.
- Tobacco use is a major public health problem in Minnesota: 22 percent of high school seniors smoke every day. This number hasn't decreased since 1989.
- Minnesota lost its ranking as the nation's healthiest state because smoking rates increased last year and are now slightly above

the national average of 23 percent.

- A 10 percent increase in the price of tobacco results in a 12 percent decrease in teenage smoking.
- Canada reduced its teen smoking rate by almost two-thirds in the 1980s by increasing tobacco taxes.
- California's rate of smoking declined following a significant increase in the tobacco tax and a state-wide prevention program.

Help Pay Costs Related to Smoking

- Tobacco use cost the Minnesota economy more than a billion dollars in 1992, including \$470 million in health care costs and \$678 million in lost income due to premature death and disability. These figures translate to \$262 per person.

• State tobacco taxes have not kept up with the rate of inflation. When the Surgeon General first announced the health implications of smoking in 1964, the state excise tax was 53 percent of the purchase price. Today it is only 37 percent.

Tax Has Popular Support

- A cigarette tax increase is the only funding source that received majority support in a recent survey, which found 65 percent of Minnesotans approve of tobacco taxes as a way to finance MinnesotaCare.
- More than 90 percent of Minnesotans believe tobacco taxes should be used for youth smoking prevention programs.
- If it would help reduce teen smoking, 46 percent of smokers would favor a cigarette tax increase.

NATIONAL NEWS

MMA/AMA URGE CONGRESS TO REFORM MEDICAL LIABILITY

There is no relief for physicians from the constant threat of career-ending litigation in H.R. 10, the "Common Sense Legal Reforms Act of 1995," one of the planks in the House GOP "Contract with America," according to the American Medical Association. This bill, which is expected to go to the House floor for a vote in early March, is the only tort reform legislation that will be going through Congress this year. Not only is medical liability reform not included, but the bill would shift liability exposure from the product sector to physicians and hospitals. It focuses only on limiting the liability of manufacturers, distributors, and retailers of products and devices. The AMA warns that this might cause plaintiffs' attorneys to redouble their efforts to succeed in suits against physicians whose liability would not be limited under H.R. 10. Doctors would be the "deep pocket."

The MMA joined the AMA in urging Congress to include liability reforms based on California's proven Medical Injury Compensation

Reform Act. MICRA reforms include a \$250,000 cap on non-economic damages, a "collateral source rule" requiring that juries be told when claimants have already been compensated by insurance, a sliding-scale limit on attorney's contingency fees, periodic payment of awards for projected future losses, a statute of limitations reform, and joint and several liability reform.

Organized medicine also urged Congress to include a limited federal preemption that would set a "floor" for the states. States that wish to go further than the MICRA model requirements should be permitted to do so. States should also be allowed to implement an alternative approach to the MICRA model that would be equally effective.

• • • • •

MMA OPPOSES MEDICARE CUTS

The MMA joined the other 49 state medical societies and 64 national medical specialty societies in signing an AMA-drafted letter to Congress and the president expressing concern about proposals to make massive cuts in federal spending on Medi-

care. The letter made these key points:

- Between 1981 and 1993, Medicare physician payments have been cut by \$39 billion. Physicians account for 23 percent of Medicare outlays but have absorbed 32 percent of Medicare provider cuts.
- Under current law there is a major gap between payment rates for private insurers and the Medicare program. In 1994, on average, Medicare paid 59 cents on the dollar.
- Congress and the administration should recognize the recent success in moderating the rate of growth in Medicare expenditures for physician services. Medicare expenditures for physician services increased by only 3 percent during fiscal year 1993. From 1990 to 1992, the average annual rates of increase in Medicare physician spending was only 5.8 percent.
- Physician payments cannot be ratcheted downward year after year without affecting access and quality of care for elderly and disabled patients.

Seminar on Cancer Pain Management

• • • • • THE MINNESOTA MEDICAL Association and the Minnesota Board of Medical Practice are jointly sponsoring a seminar on cancer pain management, which will be presented at seven locations during the spring of 1995.

After attending the seminar, participants should be able to implement the basics of whole patient management, pharmacological tools, and clinical techniques; to manage pain in the chemically dependent; and to identify possi-

ble complications. Emphasis will be on the knowledge and skills required for successful cancer pain management in a primary care setting. Faculty members include experts on spiritual care, pharmacology, oncology, and addiction medicine.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The MMA designates this CME activity for 2.0 credit hours in Cate-

gory 1 of the Physician's Recognition Award of the American Medical Association.

Dates and locations are as follows: March 22, Winona State University; March 29, Mankato State University; April 5, St. Cloud State University; April 19, Fergus Falls Community College; April 26, Hibbing Community College; May 2, Lakewood Community College, St. Paul; and May 4, Hennepin Technical College, Eden Prairie.

Each seminar begins with a buffet at 5:30 p.m. The registration fee is \$25. To register, please call the BMP at 612/642-0538.

LEGISLATIVE NEWS

CAPITATION BILL HAS HEARING

MMA chief executive officer Paul S. Sanders, M.D., testified before the House Health and Human Services Committee February 21 in support of a bill, H.F. 193-Huntley, calling for one statewide capitation rate for Medical Assistance. Currently the state uses three base capitation rates: Hennepin County, other urban, and other rural. St. Louis County physicians initiated this legislation, which responds to a resolution adopted by the 1994 MMA House of Delegates directing the MMA to work aggressively for geographic equality in General Assistance Medical Care and Medicaid capitation rates. The bill passed out of Health and Human Services and now goes to the Finance Division.

SENIORS PUSH STATE DRUG BUYING BILL

The Minnesota Senior Federation held a news conference February 9 to introduce a bill that would set up a statewide drug formulary. Introduced by Sen. John Marty, DFL-Roseville, and Rep. Linda Wejcman, DFL-Minneapolis, this bill would make the state the sole contract price negotiator for all prescription drugs sold in Minnesota and would set up a formulary of drugs that must be offered by all health plans. The state would negotiate prices with drug companies to make sure all sellers—pharmacies, HMOs, and hospitals—receive the same price on all drugs and would outlaw drug company rebates. Currently, drug companies offer rebates to HMOs and other insurers who agree to put specific drugs on their formulary. Typically, rebates are 10 to 15 percent off the discounted price. House author Wejcman claimed that the bill will “dramatically reduce the price differences between institutional and community pharmacies.” The statewide formulary would also promote the use of generic drugs

and would require disclosure of prescription drug prices. Savings are expected to be passed on to consumers, making drugs more affordable, especially for seniors and the uninsured. Medicare does not pay for prescription drugs.

Despite support for making drugs more affordable for senior citizens, this particular bill faces an uphill battle, according to MMA lobbyists. Organizations such as the Epilepsy Foundation of Minnesota oppose the bill because they fear that cheaper but less effective generic drugs would be placed on the state formulary while brand name medications would be excluded.

Last year, the MMA opposed a similar bill and expressed skepticism about the state’s ability to buy drugs for the entire state at a lower price than many patients are already paying. In addition, the MMA told legislators that a state formulary might make it hard for patients to obtain appropriate prescription drugs. An alternative proposal, asking the commissioner of health to develop recommendations for the creation of a voluntary pooled prescription drug purchasing program, was amended onto the 1993 MinnesotaCare bill in the House but was not included in the final legislation.

MMA OPPOSES BMP BILL

The MMA Board of Trustees voted to oppose a bill proposed by the Board of Medical Practice, H.F. 226-Kelly/S.F. 73-Piper, which would require hospital and medical clinics that buy professional liability insurance for physicians to report any insurance settlements paid because of care given by those physicians to the BMP. The MMA also opposes BMP legislation calling for automatic suspension of physicians’ licenses for felony conviction, discipline for physicians practicing

under a lapsed license, and discipline for failure to repay student loans.

MMA OPPOSES AG’S BILL

The MMA Board voted to oppose the Attorney General’s bill, which would allow health-related licensing boards to provide unsubstantiated complaint data and confidential data from patients’ medical records to state and federal criminal enforcement authorities. It would also allow the BMP to disseminate information from the personal medical record of the physician, including data related to drug addiction, alcoholism, mental illness, and other highly personal data. In addition, this draft bill would greatly increase the boards’ discovery authority.

MMA OPPOSES VULNERABLE ADULT ACT

The MMA Board voted to oppose the Vulnerable Adult Act as drafted by the Attorney General’s Office and directed staff to continue to develop coalitions with other health-related organizations and to negotiate in the hope of revising the bill to address MMA concerns. The bill would make it a crime to fail to report suspected abuse of a vulnerable adult. “Vulnerable adult” is broadly defined in the draft legislation as an adult “regardless of residence or whether any type of service is received, who possesses a physical or mental infirmity or other physical, mental or emotional dysfunction that impairs the individual’s ability to, without assistance, provide adequately for their own care and protection from maltreatment.” This proposal would put physicians at great risk of prosecution and would set back the MMA’s campaign to encourage women to talk to their physicians about family violence in the confidential setting of the physician’s office. Fear that their

LEGISLATIVE NEWS

abuser will be reported to the authorities is one of the main reasons women fail to tell physicians that they have been battered, according to Susan Hadley of WomanKind. The MMA has met with representatives of the AG's office to discuss concerns with this proposed legislation and has submitted a letter explaining why the MMA believes this bill would be counter-productive.

MMA Will Introduce BMP Bill

The MMA Board of Trustees decided that the MMA will introduce legislation to address a number of Board of Medical Practice issues. The MMA bill is expected to include the following proposals:

- Allow physicians under investigation to see their BMP consultant

reports before the disciplinary conference.

- Classify investigative reports as "private" so that the subject of the review has access to them. Currently, reports are classified as "confidential" and thus are not accessible to physicians.
- Classify correction orders as "not public." Currently, if a physician is disciplined by the BMP, the order is public, but if the complaint is dismissed it is not public. Since the complaint in a correction order is ultimately dismissed, the MMA believes correction orders should be treated like any other dismissal and not be made public.
- Establish a statute of limitations for BMP actions. Currently, the BMP takes the position that there is no statute of limitations.
- Allow an individual whose license

has been revoked to apply for a new license.

- Limit immunity for reporting a physician to the BMP to reports made in good faith. Limit immunity for BMP members to activities done in good faith.
- Clarify that physicians engaged in peer review do not have to report information obtained in the course of peer review and the BMP does not have access to peer review data.
- Clarify that self-reporting to the Health Professionals Service Program fulfills the physician's Medical Practice Act reporting requirement.
- Limit immunity for staff of the Health Professionals Service Program to actions done in good faith.
- Narrow the eligibility exclusion from the program for persons accused of sexual misconduct.

ANNOUNCEMENTS

SUPREME COURT HEARS SURCHARGE APPEAL

The Minnesota Supreme Court on February 2 heard an appeal of the class action lawsuit challenging the legality of the \$400 surcharge on medical licenses issued or renewed from April 1 to September 30, 1992. A ruling is expected within the next six months.

AMERICAN DIABETES ALERT

On Tuesday, March 28, the American Diabetes Association will hold a one-day public awareness campaign to identify the more than 150,000 people in Minnesota who have diabetes but don't know it. The association encourages people to call 800/DIABETES and ask for a free risk test, including questions about weight, age, lifestyle, and family

history. The most important factors for screening people who may have diabetes are: being overweight, lack of exercise, family history of the disease, and giving birth of a baby weighing more than nine pounds.

COLA HAS TOLL-FREE NUMBER

Physicians and their staff can receive timely answers to in-office testing questions by calling the Commission on Office Laboratory Accreditation's toll-free number—800/298-8044. COLA's new toll-free number connects directly to a phone center staffed by medical technologists who will answer questions on the Clinical Laboratory Improvement Act (CLIA) and other lab-related issues. The number was reactivated January 15, 1995.

The Monitor
MARCH 1995

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES
Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS
Mark S. Vukelich

EDITOR
Lorrie Holmgren

*COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes*

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C. F.
anderson
COMPANY, INC.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.



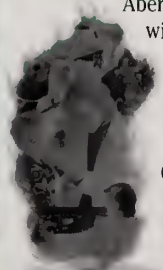
**Central Minnesota
Group Health Plan**

*Call Central Minnesota Group
Health Plan today and put time
on your side.*

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

Just for a Moment Imagine...

...what you want life and practice to be.



Aberdeen is a major regional medical center, with a modern 225-bed hospital and over 70 practicing physicians. Serving northeast South Dakota and southeast North Dakota. A community with concern for your needs and respect for your privacy.

Opportunities available:

- Family Practice • Orthopedic Surgery
- Pediatrics • Urology
- Nephrology

**Aberdeen... Life & Practice, Just
As You Imagined.**

**St. Luke's Midland
Regional Medical Center**



Contact: Bebe Janish
305 S. State Street • Aberdeen, S.D. 57401
605-622-5874

Universal Coverage: Policy Options and the Minnesota Experience

Minnesota has enacted legislation calling for universal health care coverage. The policy options for achieving this goal are numerous, as are the challenges.

Janet Silversmith

Minnesota enacted legislation in 1994 articulating the state's public policy commitment to achieving universal health care coverage for all Minnesotans by July 1, 1997.¹ With the demise of national health system reform, all states face significant challenges in achieving universal coverage. In Minnesota, some policymakers are re-evaluating the goal of universal coverage and calling for a delay in the implementation date or even suggesting that the state pursue universal access instead. Meanwhile, its advocates argue that universal coverage is an essential, not an expendable, aspect of health system reform. This article describes the rationale for seeking universal coverage, defines the population targeted for coverage—the uninsured—discusses some of the policy options available for achieving universal coverage, highlights Minnesota's universal coverage strategy and success to date, and discusses challenges Minnesota faces in seeking to make universal coverage a reality.

To many people, universal coverage is as basic as mom and apple pie. Debate most often focuses on how universal coverage can be achieved, not on whether it should be attempted. The recent congressional debate, however, illustrated the fact that simply defining the term "universal coverage" can be as controversial as deciding how to achieve it. Congress spent countless hours trying to define universal coverage in terms of an acceptable percentage of the population that must be covered to achieve "universal coverage." Congress found itself trapped in this debate in response to assertions made by some policymakers and others that universal coverage could not truly be obtained in the absence of a single-payer system. Coverage of 96 percent of the population, for example, was often cited as an acceptable percentage of the population by which successful reform efforts could be measured. It is critical to develop a common definition for universal coverage for the purpose of making public policy decisions; however, this article discusses policy options available for achieving universal coverage given a variety of definitions. One could pick and choose from the various options to

produce numerous "types" of universal coverage.

Minnesota, through the work of the Minnesota Health Care Commission, defined universal coverage to mean a source of payment exists for every person's health care, and every Minnesotan pays into the system according to his or her ability.² This definition does not necessarily imply that every individual will be enrolled in a health plan, recognizing that there will always be some people who remain uninsured either voluntarily or involuntarily. It is important to be cognizant of this definition when reviewing Minnesota's strategy for achieving universal coverage.

RATIONALE FOR UNIVERSAL COVERAGE

The reasons for seeking universal coverage are practical as well as philosophical. From a philosophical perspective, many people consider health care coverage (and access to health care) to be a fundamental right. A commitment to universal coverage in this respect assumes a decision to share the costs of health care across society. In this vein, achieving universal coverage meets the moral obligation inherent in providing people with basic rights.

Practically, the absence of universal coverage means that many people without coverage will use health care services inefficiently, and their care will be paid for inefficiently through cost-shifting practices. When health care is provided to the uninsured, or to those unable to pay the full cost of their care, health care providers are forced to shift those costs to people who are able to pay.

The uninsured have difficulty gaining access to the health care system and tend to use less care than those who are insured; they also receive fewer preventive services than the insured population.³ Persons lacking insurance tend to seek care later, at a more advanced stage of disease, and have higher mortality rates than the insured population.⁴ Uninsured persons are also more likely to use emergency departments to obtain care.⁵ Clearly, emergency care is more expensive than care provided at the onset of symptoms in ambulatory settings. One concern often raised about universal coverage

is that it will increase the use of health care services by the previously uninsured, and thus, raise costs. A recent study, however, estimates that universal access would result in only a 4 percent per year increase in ambulatory contacts and inpatient days, and a 2 percent increase in total health care spending.⁶

According to a study conducted by the health care consulting firm Lewin-VHI, one of the most important reasons for achieving universal coverage is to avert increases in average premium costs that could result from health system reform absent universal coverage.⁷ Lewin-VHI contends that a non-universal approach to health system reform, i.e., insurance market reforms and minimal subsidies, would result in average premium increases because only higher consumers of health care, such as those with pre-existing conditions, would be brought into the system. As a result, the level of risk of the insured population would rise and premiums would go up. Young, healthy people leave the insurance pool as prices increase, thereby further driving up premiums, Lewin-VHI argues. Universal coverage, in contrast, would bring all people into the insurance pool, thereby spreading the risk across a broad group, including healthy individuals who contribute to the cost of coverage but are unlikely to overutilize care.

THE UNINSURED

HISTORICAL ANALYSIS

If extending health care coverage to the currently uninsured population is a primary goal of health system reform, an obvious question emerges: how did the American health care system allow this problem to occur? An answer can be found in the historical development of health care financing.

Thomas Bodenheimer and Kevin Grumbach have defined four fundamental methods of paying for health care: out-of-pocket payment, individual private insurance, employment-based group private insurance, and government financing.⁸ Bodenheimer and Grumbach argue that these methods can be viewed as progressive solutions to problems created by earlier methods.

Out-of-pocket payments, in which a consumer purchases services directly in cash or barter, represented the primary method of paying for health care in the 19th and early 20th centuries. Most purchases, such as for clothing and other consumer goods, are made this way. Purchasing goods is primarily a discretionary and predictable decision, whereas purchasing health care is often an urgent and unpredictable decision. In addition, if health care is considered a "right," an out-of-pocket payment mechanism alone is ineffective in financing health care for those with nothing in their pockets. For these reasons and others, Bodenheimer and Grumbach contend, direct purchasing of health care services became increasingly difficult for consumers and was inadequate in providing payment to hospitals and physicians. Health insurance developed as a solution.

In general, private health insurance involves the use of a third party (insurer) as the intermediary between

individuals and the health care provider. In the early part of the 20th century, various employers, unions, and fraternal groups began to provide "sickness benefits" for their members.⁸ Metropolitan Life and Prudential did provide individual insurance policies; however, the administrative costs involved in collecting from the individual policyholders became a significant obstacle to the expansion of this form of coverage.⁸

The Depression of the 1930s had dramatic effects on the health care system as people faced increasing difficulties in paying for their health care. Between 1929 and 1930, the average hospital receipts dropped from roughly \$200 per patient to less than \$60.⁹ As hospitals struggled for survival, and people struggled with the cost of hospital care, hospital-centered private insurance plans were developed. In 1929, Baylor University Hospital was among the first to agree to provide 21 days of hospital care to 1,500 Dallas schoolteachers if they paid the hospital \$6 per person per year.¹⁰ The Baylor University concept soon spread. The American Hospital Association built on this system and established statewide Blue Cross plans through which participating hospitals agreed to provide services to subscribers who paid their premiums to the plan rather than to individual hospitals. In a parallel move, the California Medical Association established the first Blue Shield plan to cover physician services; similar state medical society-run plans soon emerged across the country.¹¹ The development of these plans changed the concept of traditional insurance (protection from large, unforeseen expenses) and dramatically changed the health care system. Interestingly, the rapid escalation of health care coverage, which provided individuals a predictable method of paying for their health care, was primarily initiated by health care providers (hospitals and physicians) as a way of securing income.

The growth of employment-based insurance was largely a result of the wage and price controls prevalent during World War II. Health insurance, which was determined to be tax-deductible, was used as a legitimate fringe benefit in attracting scarce workers; unions continued to negotiate on this issue even after the war ended as part of collective bargaining arrangements. The number of people in group hospital insurance plans increased from 12 million in 1940 to 101 million in 1955.¹² Commercial insurance companies quickly began to compete with the Blue Cross and Blue Shield plans for a share of the employer-sponsored health insurance market. Commercial insurers became effective competitors by using an insurance tool known as experience rating.

Experience rating, in which premiums are calculated according to the expected use of health care services by individuals or groups, allowed commercial plans to offer less expensive premiums to healthier groups. Community rating, in contrast, redistributes dollars within groups and among groups. Bodenheimer and Grumbach illustrate the difference with an example that includes a group of young, healthy bankers; a group of older, healthy truck drivers; and a group of older coal miners with a high rate of chronic illness. Experience rating allows the bankers to pay less than the truckers and even

less than the miners in premium dollars. Although healthy bankers will subsidize sick bankers, healthy bankers will not subsidize sick miners. Under community rating, however, all three groups pay the same premium, and the healthy bankers subsidize the premiums of the sicker miners.

Experience rating helped commercial insurers surpass the "Blues" in enrollment; by 1955, 54 million people were enrolled in commercial plans, and 51 million were enrolled in the Blues.¹² The 51 million enrollees in the Blues plans were also, theoretically, sicker, more expensive people than those in commercial plans. Commercial plans were unlikely to market to high-risk groups, and there was no financial incentive for high-risk groups to choose commercial plans; there was also no financial reason for healthy groups to buy in a community-rated market. In a move to remain competitive, most Blue Cross and Blue Shield plans switched to experience rating.

With the loss of community rating, older and sicker groups of people became less able to afford health insurance.⁸ Ultimately, the health insurance mechanism designed to solve the problem of direct out-of-pocket payment for health care created additional problems.

Government financing represents the final financing method described by Bodenheimer and Grumbach. The expansion of employment-sponsored health insurance and the shift toward experience rating had significant impact on two principal groups—the poor and the elderly. The poor, often unemployed or employed in jobs without health insurance benefits, were unable to afford insurance. The elderly, who benefited from subsidized premiums under community rating, also became increasingly unable to afford insurance as experience rating expanded. By the late 1950s, only 15 percent of the elderly had health insurance.¹³ The inevitable solution was tax-financed government health insurance.

The government was involved in health care financing prior to the 1960s, primarily through education programs and facility development. Not until the passage of Medicare and Medicaid in 1965, however, was the government involved in financing public insurance for privately operated health care services. In addition to the redistribution inherent in private insurance, from healthy to sick, tax-financed insurance adds another redistribution—from wealthy to poor. Although government financing provided access to care for some groups, it also served to aggravate the problem of rising costs.⁸ As cuts in Medicaid services denied low-income persons access, the coverage gaps in the Medicare program created problems for the elderly. In addition, employers continued to see increasing costs for private insurance.

Bodenheimer and Grumbach analyze the evolution of the United States' problem of the uninsured. Private insurance was developed to protect patients against the unpredictable costs of medical care, as well as to protect providers against the unpredictable ability of patients to pay. Three problems emerged from this method: 1) providers were able to increase fees to insurers, thereby decreasing affordability to those without insurance; 2) employment-based insurance hurt the unem-

ployed, retired, and part-time employed, and served to insulate those covered by employer-provided health insurance from the actual costs of insurance; and 3) competition in the insurance market encouraged the practice of experience rating, which further limited affordability for the elderly and poor. The introduction of government-financed health care coverage contributed to increasing inflation in health care costs.⁸

CHARACTERISTICS OF THE UNINSURED POPULATION

A context for the origin of the uninsured is useful in describing characteristics of the current uninsured population. Nationally, about 17 percent of the population (about 37 million people) under age 65 was determined to be uninsured during 1992.¹⁴ Based on research conducted for the Minnesota Health Care Commission (MHCC), approximately 8.9 percent of Minnesota's population (or about 400,000 people) is uninsured at any point in time.¹⁵ Changes in the rate of the uninsured appear to differ markedly between Minnesota and the nation as a whole. Minnesota's uninsured rate remained constant between 1990 and 1993; however, the national rate increased by roughly 0.33 percent per year.¹⁵ An explanation for the steadily increasing numbers of uninsured is complex; however, it is clear that there is a constant erosion of voluntary employer-based health insurance.¹⁶ Between 1987 and 1992, the percentage of the national population with employer-based coverage fell from 62.1 percent to 58.3 percent.¹⁵ Some of the changes that seem to account for this change include a shift from large-employer, capital-intensive industries toward small-employer, labor-intensive ventures; a rapid increase in the proportion of "contingent jobs"—part-time, temporary, or contractual; and the high turnover rate in the job market.¹⁶

The uninsured are not a homogeneous group; they cross age groups, income levels, and social classes. Based on research done for MHCC, nearly half of Minnesota's uninsured (47 percent) are between the ages of 25 and 44.¹⁵ In comparison, about 40 percent of the nation's uninsured are between 25 and 44 years of age.¹⁴ In Minnesota, however, only 13 percent of the uninsured are less than 18 years of age, while 23 percent of the national uninsured are younger than 18.¹⁴ Not surprisingly, income level accounts for dramatic differences between the insured and uninsured. Seventeen percent of uninsured Minnesotans had incomes below the federal poverty level, while 28 percent of the uninsured nationally had incomes below poverty.¹⁴ Thirty-seven percent of Minnesota's uninsured have incomes between 100 percent and 200 percent of poverty (compared with 32 percent nationally); however, only 16 percent of insured Minnesotans fall in this income range.¹⁴ Surprisingly, about 28 percent of the uninsured in Minnesota have incomes above 300 percent of the poverty level and, therefore, do not qualify for the state's health care programs—General Assistance Medical Care or Minne-

*The 1992 federal poverty level was \$11,570 for a family of three.

sotaCare. This segment of the uninsured population may be uninsured for reasons other than purely financial, e.g., because of pre-existing condition limitations or because they choose not to purchase coverage. More important, implementing various universal coverage options may allow this group to become insured without the need for public assistance in paying the cost of premiums.

Source of employment is another important determinant of insurance status. Seventy-two percent of Minnesota's uninsured population is employed; however, employment is most often in the service, clerical, or labor fields, as opposed to managerial or professional occupations.¹⁵ Finally, Minnesota's uninsured are far more likely to be male (63 percent) than female. In conclusion, Minnesota's uninsured are more likely than the insured population to be male, between 18 and 34 years of age, and have low to very low incomes.¹⁵

POLICY OPTIONS FOR ACHIEVING UNIVERSAL COVERAGE

Without a single formula for achieving universal coverage, states can choose from various approaches to create a system of universal coverage that best meets their needs. It is not the intent of this article to recommend which approach is most appropriate; rather, this article simply discusses the various options available. Regardless of the methods chosen, states must accomplish three tasks: 1) define the universe in the universal coverage strategy (i.e., who is the target population for reform efforts?—Possibilities generally include the currently uninsured, all people below a particular income level, or uninsured children); 2) determine the level of coverage and secure that coverage (i.e., select a level of benefits for persons and identify mechanisms that ensure those benefits are available—enforce and guarantee coverage); and 3) choose a source of financing (i.e., determine how payments will be collected to finance coverage for the identified universe).¹⁷ Resolving these three issues will guide decision makers through available policy options. The issues of financing and coverage are defined by Alan Krueger and Uwe Reinhardt, who argue that there are three "facts of life" to remember when it comes to health system reform: 1) all dollars used to finance health care ultimately come from private individuals; government and business are simply intermediaries in the current process; 2) universal coverage requires transfers of dollars from households in the upper half of the nation's income distribution to households in the lower half; and 3) ensuring universal coverage requires a mandate.¹⁸

Defining the universe, or the target population for a universal coverage strategy, is fairly straightforward. Many states, including Minnesota, have focused reform on the current population of uninsured. This approach assumes a level of comfort with employer-based health care coverage, because it does not intend to dismantle that structure or redefine the universe to include anyone except the uninsured. More incremental approaches to universal coverage might focus on specific segments of

the population, such as uninsured children. The Children's Health Plan, the precursor to the current MinnesotaCare program, originally targeted uninsured children for coverage.

A single-payer approach to health system reform would define the universe as all individuals, regardless of their current source of insurance coverage. Single-payer policies rely on the tax system for financing health care for all persons. Coverage, usually guaranteed through a government-run program, is granted to all residents or citizens and is not subject to such conditions as employment status.

Determining the level of coverage and how to secure it are among the most difficult and controversial aspects of any universal coverage proposal. The level of coverage, or the benefits set, is an extremely important topic but will not be discussed here. (For a thorough discussion of this issue, see the MMA Guaranteed Benefits Task Force Report in the November 1994 issue of *Minnesota Medicine*, page 46.)

Securing universal coverage can be accomplished through three primary strategies—mandates, insurance reform, and purchasing pools. Arguably, mandates are the most direct approach to assuring a high level of compliance with universal coverage strategies. Insurance reform and purchasing pools can be viewed as either tools to achieve a more incremental version of universal coverage, or as tools to make coverage more affordable and accessible under a universal coverage program.

MANDATES

The subject of governmental mandates often generates intense debate. To many people, a mandate represents state authority at the expense of personal freedom. The classical American political philosophy favors personal freedom and distrusts government involvement unless based on a compelling argument.¹⁹ Two compelling arguments have been advanced for a government mandate for universal coverage. The first is a direct result of Americans' belief in personal freedom. Without a mandate, millions of Americans would choose to remain uninsured, even if they could afford to purchase insurance, because we have a somewhat catastrophic health insurance system in place: Hospital emergency departments are obligated to treat those who present for care.¹⁸ For many members of society, the existence of emergency departments is an invitation to remain uninsured. The second compelling argument is that a mandate of sorts currently exists—a mandate on taxpayers.¹⁹ As mentioned above, care provided to the uninsured is currently paid for by those who have coverage (through cost-shifting practices), and by publicly funded programs such as Medicaid. An explicit mandate would, advocates argue, more equitably finance coverage for all Americans.

The purpose of a mandate is to identify the entity responsible for obtaining or providing coverage—the government, the employer, or the individual. A mandated, government-financed proposal, such as the Canadian model, is a clear-cut approach to universal coverage.

Americans, however, have historically been opposed to this option, primarily because they are distrustful of a system run by the government. Ironically, however, more than 42 percent of all national health care spending is based on this model, which covers 25 percent of the population through Medicare, Medicaid, the Department of Veterans Affairs, and various Public Health Service programs.¹⁸

As previously discussed, the employer-based health insurance system found throughout this country was created more as a result of historical circumstances than as a result of overt policy decisions. Advocates of an employer mandate argue that utilizing this already extensive system is the most expedient choice. For states, however, the use of an employer mandate is a difficult choice given the legal limitations (see discussion of ERISA below).

An individual mandate places the responsibility for obtaining coverage on the individual—an approach that raises two concerns. First, an individual mandate would require a plan for subsidizing the cost of coverage for individuals unable to afford the full premium. And second, enforcement of an individual mandate would be difficult and would need to balance administrative simplicity with accuracy. Theoretically, it should be easier to ensure compliance with an employer mandate because of the smaller numbers. Minnesota has chosen an individual mandate to achieve universal coverage. Unless the 1994 law is changed, all individuals will be required to obtain and maintain coverage effective July 1, 1997.

INSURANCE REFORM

Not all the uninsured lack insurance because they can't afford it. Approximately 28 percent of the uninsured in Minnesota have incomes above 300 percent of poverty. For a portion of these people, poor health histories, age, or occupation may be barriers to obtaining health insurance. Securing and mandating coverage for this segment of the uninsured population could likely be accomplished by improving the availability, accessibility, and affordability of private coverage through insurance reform that is primarily directed at the small-group and individual markets—the groups that have most commonly faced obstacles to obtaining affordable coverage. The primary purpose of insurance reform is to regulate underwriting and eliminate such barriers.

The several components involved in insurance reform can be utilized alone or in any combination. The major insurance reform provisions utilized in health system reform efforts are 1) guaranteed issue and renewability, which requires insurers to issue and renew health care coverage to anyone who desires it, regardless of health status or risk; 2) community rating, which is designed to spread the costs and risk of health care coverage more evenly across large populations; 3) elimination of underwriting for pre-existing conditions; and 4) portability of coverage, which would allow people to move from one health plan to another without being denied coverage or subjected to pre-existing condition limitations (this is essentially achieved through implementation of the other pieces).²⁰

For states seeking more incremental approaches to universal coverage, insurance reform is often used as a starting point. Notably, Republican members of Congress are supportive of various aspects of insurance reform as a way to advance health system reform.²¹ Policymakers are concerned, however, that insurance reform without mandates for coverage will create perverse incentives for individuals. For example, healthy people could drop their insurance if they knew they could readily obtain coverage if they got sick or injured.⁵ In addition, there is skepticism about insurance reform alone as a means to achieve universal coverage. Assuming a national uninsured population of about 37 million people, insurance reform alone would only reduce the number of uninsured by an estimated 1 million people.⁷

Minnesota has included insurance reform provisions in its plan to achieve universal coverage. It is important to remember that Minnesota also has an individual mandate, so insurance reform in the Minnesota model is viewed as an integral part of a more comprehensive universal coverage strategy. The two major goals of Minnesota's insurance reform provisions are guaranteed issue and renewability and community rating.²⁰ Minnesota's insurance reform plan is based on a gradual implementation schedule, which began in 1992 and, under current law, is expected to be fully implemented by July 1997, although the Legislature may delay some provisions. Effective January 1993, 100 percent of premiums for self-employed persons can be deducted from state income. By July 1993 for small-group and individual markets, variation in rates for gender are prohibited; rate bands of +/-50 percent for age are allowed; guaranteed issue in the small-group market is required, as is guaranteed renewal in both small-group and individual markets; and pre-existing condition clauses are restricted. As of July 1995, the size of the small-group market changes from 2 to 29 employees to 2 to 49 employees, and rate bands are narrowed to +/-25 percent for age. By July 1996, rate bands are further narrowed to +/-15 percent for age. And effective July 1997,[†] the state is calling for full implementation of unconditional guaranteed issue and renewability, portability of coverage across all markets, elimination of underwriting and pre-existing condition limitations, and full community rating.²⁰

PURCHASING POOLS

Like insurance reform, purchasing pools (sometimes called cooperatives, alliances, or coalitions) are designed to help increase access to affordable private health care coverage for small employers and individuals. Purchasing pools are like purchasing agents with the economic clout to negotiate the best rates for individuals and employees of smaller firms. The use of purchasing pools to buy health care services raises numerous concerns: Should the use of pools be voluntary or mandatory?

[†]Provisions effective July 1997 are conditional on further legislative action based on the results of various studies of the effects of insurance reform provisions.

Should employers of all sizes use pools? Should purchasing pools be considered for profit or nonprofit? Purchasing pools (or health insurance purchasing cooperatives) generated considerable discussion as a central feature of President Clinton's original health system reform proposal. The Clinton plan would have required all employers with fewer than 5,000 workers to participate in the regional alliances.

As part of Minnesota's comprehensive approach to achieving universal coverage, the 1992 Legislature created the Minnesota Employees Insurance Program (MEIP), a state-administered voluntary purchasing pool for private employers. Small employers (2 to 29 employees) are typically involved with MEIP; currently, four health plans participate in the pool, and approximately 3,000 individuals are covered. According to data furnished to the Minnesota Health Care Commission, 78 percent of the people covered by MEIP were not covered by health insurance prior to joining MEIP. Minnesota also administers a pool for state employees (the State Employee Group Insurance Pool), as well as one for public employers (the Public Employers Insurance Program). The PEIP program is primarily composed of small governmental entities that were previously unable to purchase health care coverage for their employees. During the 1994 legislative session, additional purchasing pool provisions were created to make it easier for private pools to form based on shared characteristics, such as a common geographic region or similar employment.

Minnesota's approach to the development of purchasing pools has focused on the public sector. Private-sector initiatives exist, but the state has not actively facilitated or required their formation. It is the state's policy to allow the private sector to create purchasing pools when and if businesses want to use them.

FINANCING UNIVERSAL COVERAGE

Financing is central to the concept of universal coverage. Krueger and Reinhardt contend that there are three fundamental policy options for financing health care: 1) individuals purchase coverage directly from insurance carriers; only about 10 percent of the non-elderly U.S. population buys coverage in this manner; 2) the government taxes individuals and the revenue is placed in an insurance fund to cover the population; this form of financing, common in Canada and European nations, accounts for 25 percent of the U.S. population; and 3) private and public employers purchase coverage for employees from private insurance carriers; about 71 percent of the nation's nonelderly population receives coverage through this financing mechanism.¹⁸ The current financing strategy in the United States is a complex combination of all three options. For the purpose of this article, financing universal coverage means how coverage will be purchased, not how additional revenue will be collected. That is, for this discussion, financing does not mean what taxes, if any, would be needed to pay for universal coverage.

Although Minnesota has chosen a universal coverage strategy based on an individual mandate, it is not the

state's intent to dismantle the employer-based provision of health care benefits. Rather, the state seeks to ensure coverage of the current uninsured population through the use of the individual mandate. Given the focus on the uninsured, it is clear that public subsidies are necessary to help that population comply with the mandate. The MinnesotaCare program, begun in October 1992, set up the structure to provide state-subsidized health care coverage to low-income, uninsured Minnesotans.

The MinnesotaCare program expanded on the Children's Health Plan, which was enacted in 1988 to provide limited coverage to uninsured children. The MinnesotaCare program, which is a sliding-scale, premium-based plan, currently provides coverage to families who have children and are at or below 275 percent of the federal poverty guideline.[‡] In October 1994, adults without children became eligible for the program if they were at or below 125 percent of the federal poverty guideline. Since its inception, more than 91,000 individuals have enrolled in the MinnesotaCare program.²⁰

Absent an employer mandate, and depending on the design of a subsidy program, employers and insured individuals may find incentives to drop coverage and utilize the publicly subsidized program. This response, known as the erosion effect, has the potential to radically change the expected size of the target population and, consequently, the cost of the program. The subsidy program must be carefully designed to prevent or minimize the erosion of private coverage; the MinnesotaCare program created three principal barriers: 1) to be eligible, a household must have been uninsured for four months; 2) to be eligible, a household must not have had access to employer-subsidized coverage within 18 months; and 3) inpatient hospitalization coverage is capped at \$10,000. The purpose of these barriers is to make the subsidy program less attractive to those currently insured, thereby keeping the focus of the subsidy program on the uninsured.

ERISA: AN OBSTACLE TO STATE REFORM

Universal coverage is often just one component of broader health system reform efforts. The lack of federal reform has left many states questioning the true impact of state reform. Apart from the political obstacles inherent in financing state universal coverage subsidy programs, states face a serious obstacle, not only in achieving universal coverage but also in advancing other aspects of reform, in the form of the Employee Retirement Income Security Act of 1974 (ERISA).

The primary purpose of ERISA originally was to protect the financial solvency of workers' pension and health benefits and to give employers more flexibility in designing benefits plans.²² One provision, however, exempts companies that choose to self-insure (employers

‡The 1994 federal poverty guideline (FPG) for a single individual is \$7,360, for a couple it is \$9,840, and for a family of three is \$12,320.

pay their employees' health care bills out of a pool of money instead of from commercial insurance premiums) from a variety of regulations, including state-mandated benefits, data collection, insurance reform, and premium taxes.²² According to preliminary, unpublished data from the Minnesota Department of Health, approximately 30 percent of Minnesotans are covered by self-insured health plans, thereby insulating them from the state's reform efforts. Nationally, as many as 65 percent of employers self-insure.²²

There is concern among policymakers that ERISA has, in effect, exacerbated a "winners" and "losers" system as states seek to standardize aspects of health care delivery. For example, the case of *McGinn v. H&H Music Company* illustrates the potential inequities allowable under ERISA. Recently affirmed by the Supreme Court, an employer, H&H Music Company, was permitted to reduce lifetime medical benefits from \$1 million per participant under a commercial policy to \$5,000 for AIDS-related claims under a self-insured plan after learning that one of its employees had AIDS.²³ Although this case may be treated differently today under the Americans with Disabilities Act, there is concern that the precedent has been set to allow after-the-fact termination or reduction of benefits for other high-ticket health problems such as cancer, while leaving states powerless to halt such activities.²³ States pursuing comprehensive health system reform are severely limited by ERISA, and many are interested in obtaining "waivers" from aspects of the law, which requires congressional action. To date, only Hawaii (in 1983) has obtained a waiver, arguing that its 1974 employer mandate predated the passage of ERISA.²⁴

States seeking ERISA waivers, however, will be confronted by a unified force—business and labor. Business argues that state mandates are costly, constantly changing, and often frivolous. Business also believes that mandates and state-by-state regulation limit the ability of businesses to design plans that meet the needs of workers, particularly if the business has operations in several states.²² Labor, on the other hand, is concerned with the impact ERISA changes may have on current benefits. Workers worry that state reforms, through standard benefits packages, may reduce benefits currently available. Labor prefers national standards and national enforcement of health system reform measures.²²

Because federal health system reform is at ground zero, Congress will need to address the issue of state-level reform. If Congress is supportive of states' efforts to proceed with health system reform, it must determine the appropriate role of ERISA in regulating health care delivery and financing. The future of universal coverage in Minnesota and elsewhere is largely dependent on this issue.

CONCLUSION

Support for universal coverage is waning nationally and in Minnesota. As the 1995 Minnesota Legislature grapples with the future of health system reform, the issue of universal coverage is certain to receive considerable attention. As discussed here, several potential options

exist should Minnesota alter its previously charted course for achieving universal coverage.

MM

Janet Silversmith is a health policy analyst for the Minnesota Medical Association.

REFERENCES

1. Minn. Stat. 62Q.16.
2. Minnesota Health Care Commission. Universal coverage report. Minneapolis: Minnesota Health Care Commission, 1994 February 1.
3. U.S. Congress, Office of Technology Assessment. Does health insurance make a difference? Washington, D.C.: U.S. Government Printing Office, September 1992. Background Paper, OTA-BP-H-99.
4. Franks P, Clancy CM, Gold MP. Health insurance and mortality: evidence from a national cohort. JAMA 1993;270:737-41.
5. Minnesota Health Care Commission. Affordable financing of universal coverage [Draft report]. Minneapolis: Minnesota Health Care Commission, 1994 November 29.
6. Long S, Marquis MS. The uninsured access gap and the cost of universal coverage. Health Aff 1994;13(2):211-20.
7. Lewin-VHI, Inc. Coverage, premium, and household spending implications of health reform. Washington, D.C.: The Catholic Health Association of the United States, Division of Government Services, 1994 July 18.
8. Bodenheimer T, Grumbach K. Paying for health care. JAMA 1994;272:634-9.
9. Wasley TP. What has government done to our health care? Washington, D.C.: The Cato Institute, 1992.
10. Fein R. Medical Care, medical costs. Cambridge, Massachusetts: Harvard University Press, 1986.
11. Starr P. The social transformation of American medicine. New York, NY: Basic Books, 1982.
12. Source Book of Health Insurance Data, 1990. Washington, D.C.: Health Insurance Association of America, 1990.
13. Harris R. A sacred trust. New York, NY: The New American Library, 1966.
14. Rowland D, Lyons B, Salganicoff A, Long P. A profile of the uninsured in America. Health Aff 1994;13(2):283-7.
15. Minnesota Health Care Commission. Preliminary estimates of the number of uninsured Minnesotans: staff report to the Minnesota Health Care Commission. Minneapolis: Minnesota Health Care Commission, 1994 October 4.
16. Davis K, Schoen C. Universal coverage: building on Medicare and employer financing. Health Aff 1994;13(2):7-20.
17. Grossman EG. Comparing the options for universal coverage. Health Aff 1994;13(2):84-100.
18. Krueger A, Reinhardt U. The economics of employer versus individual mandates. Health Aff 1994;13(2):34-53.
19. Moffit R. Personal freedom, responsibility, and mandates. Health Aff 1994;13(2):101-4.
20. Minnesota Health Care Commission. Minnesota health reform master plan. Minneapolis: Minnesota Health Care Commission, June 1994.
21. Republican leaders likely to pursue scaled-back reforms in new congress: BNA's health care policy report. Washington, D.C.: Bureau of National Affairs, 1994 November 21.
22. Tokarski C. ERISA: health reform's first hurdle [Perspectives]. Med Health (Faulkner & Gray's) 1993 January 11.
23. Chirba-Martin M, Brennan T. ERISA and state reform. Health Aff 1994;13(2):142-56.
24. Dixon L. ERISA: states push to raze the biggest barrier to health reform. State Health Notes (George Washington University), 1994 November 14.

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care - at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183



Family Practice & Psychiatry

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 150 professionals who offer care at 9 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441
EOE

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Pediatrics
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

M MULTICARE • ASSOCIATES
OF • THE • TWIN • CITIES

People and Places Making Medical News

People

HCMS CEO

The Hennepin County Medical Society has named **Jack Davis** new chief executive officer. Davis succeeds **Tom Hoban**, who retired January 31 as executive vice president and chief executive officer after more than 25 years at the medical society.

Davis was formerly president and chief executive officer for Select Care, a preferred provider organization based in Bloomington.

Children's Health Care CFO

Children's Health Care, the organization formed by the merger of Children's Hospital of St. Paul and Minneapolis Children's Medical Center, has named **Jerry L. Massmann** chief financial officer. He began his duties at Children's on January 9. Previously, he served as chief financial officer/vice president of finance for MultiCare Health System, based in Tacoma, Washington. He was vice president of financial operations for Health One Corp. from 1985 to 1991.

Duluth Clinic President

The Duluth Clinic Board of Directors elected **Peter E. Person, M.D.**, president in late January. Person specializes in internal medicine at Duluth Clinic.

Russian 'Piece Prize'

Minnesota physician **Donnell D. Etzwiler, M.D.**, president of the International Diabetes Center in Minneapolis, received a piece of a dismantled Russian missile as a "piece prize" from the Russian government for his work in diabetes treatment and education

in that country. The award symbolizes the peace between the United States and Russia making such a medical collaboration possible.

The International Diabetes Center and the Russian Academy for Advanced Medical Studies began a grass-roots peace effort in 1988 and through their efforts were able to establish diabetes diagnostic, treatment, and educational centers in 30 sites throughout the region; publish 2 million patient care manuals; and begin a quarterly journal for health professionals and a magazine for patients.

CMN Manager

The Children's Miracle Network has named **Darlis Clausen** manager of its local affiliate. CMN, a national fundraising organization supporting 160 hospitals in the United States and Canada, raises money locally for Children's Health Care—St. Paul and Gillette Children's Hospital. Clausen previously held positions with the March of Dimes Birth Defects Foundation.

Places

Children's Health Care Receives Grants

Midwest Children's Resource Center (MCRC), a child abuse evaluation and treatment program at Children's—St. Paul, has been awarded two separate grants to develop new programs and systems. MCRC is one of 26 organizations nationally to be awarded a program development grant from the National Network of Children's Advocacy Centers. It will use the \$25,000 grant to develop a computerized child abuse case tracking system linking MCRC with Ramsey County Human Services and the Ramsey County

Attorney's Office. Wilder Research Center will provide technical assistance in developing tracking forms, database management, and communication links.

MCRC also has been awarded a \$10,000 grant from the Minnesota Department of Human Services to develop a training curriculum to teach medical professionals how to identify child maltreatment. The curriculum also will address guidelines for treatment, referral, and consultation in abuse and neglect cases.

MCRC performs more than 1,200 evaluations for child abuse and neglect each year and provides more than 2,200 phone consultations annually for health care and legal system professionals throughout the Upper Midwest.

St. Paul-Ramsey Opens Dialysis Clinic

St. Paul-Ramsey Medical Center opened a new dialysis clinic in Woodbury in January to meet the needs of a growing number of patients with advanced kidney disease. The clinic, called Ramsey Dialysis-Woodbury, is intended to ease the strain on the hospital's dialysis centers in downtown St. Paul and at Lakeview Memorial Hospital in Stillwater, both of which are treating close to their capacity of patients. "We have seen a steady increase in the cases of end-stage renal disease in our program. The need for a new dialysis center, particularly in the east-metro region, has become acute," said **Sally Ehlers, M.D.**, medical director of the Ramsey dialysis program.

Ehlers attributes the increased need for kidney dialysis to medical technology and techniques that allow longer life spans for seriously

ill people, and to a shortage in donor kidneys. Although Minnesota's transplant centers rank highest in the nation for number of kidney transplants performed, 1,822 Minnesotans rely on dialysis treatments three times each week to stay alive, according to National Kidney Foundation statistics.

Medtronic Gets FDA Approval on Latest Pacemaker

Fridley-based Medtronic, Inc., received FDA approval to market its latest pacemaker—called the Thera—in the United States. Medtronic received word in January that it could market five Thera pacemaker models, all of which use the same programming and reprogramming commands to ease physician use of the devices. The five Thera models have been on the market in Europe since last March.

Socioeconomics

BHCAG Offers Innovative Plan

The Business Health Care Action Group (BHCAG) announced in February that it will restructure the health plan it offers to employees of its 22 member companies by expanding the choice of medical clinics—a move that could shake up the local health care market.

Under the new arrangement, which goes into effect in two years, BHCAG will no longer work within the confines of only one health plan, as it has since 1993, but will allow other groups to compete for business.

BHCAG has extended its contract through 1997 with HealthPartners, which along with the Mayo Clinic and HealthSystem Minnesota has made up the network of 50 medical groups and 900 primary care physicians in the coalition's Choice Plus plan, which has about 97,000 members.

The influential purchasing coalition plans in 1997 to open the door to other care systems in the Twin Cities metro area and in outstate Minnesota, eastern North

and South Dakota, and western Wisconsin. The move will offer a wider choice of physicians, hospitals, and clinics to the 250,000 employees, retirees, and dependents who are in the coalition's health care purchasing pool.

The change will also create more competition among providers and may slow health care mergers and consolidations in the Twin Cities, as health plans would no longer be under pressure to create networks spanning the entire metro

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

612-885-6224

1-800-842-6469



area to attract large purchasers like BHCAG.

The revamped plan means that competing health systems, such as Allina, Fairview, and the University of Minnesota, could bid to have some of their clinics included in the Choice Plus plan. In the current market, industry players usually sell an entire health care network and administrative services as a package.

New Delivery System Formed in St. Cloud Area

Ninety-six St. Cloud-area physicians are joining together to form The Minnesota Clinic, an organization of 23 independent area medical practices collaborating in an effort to improve continuity of medical care and to reduce costs.

"Basically, we are responding to market demands," said Nelson Sirlin, M.D., a St. Cloud-based gynecologist who serves as chair of a 17-member physician executive committee responsible for organizing The Minnesota Clinic. "People paying the bill want a more affordable product, and the physicians delivering the care want to be sure they are not sacrificing quality."

The clinic, expected to begin functioning in April, is designed as a multispecialty delivery system involving both primary care and specialty physicians. The affiliated clinics, which own and govern The Minnesota Clinic, will continue to practice in their current locations as independent practices but will jointly develop protocols for the coordination of medical services, quality assurance and review programs, computerized information systems, as well as other programs and systems to improve the delivery of medical services.

Fairview and Ebenezer to Affiliate

Fairview Health Systems and the Ebenezer Society have signed a memorandum of understanding to affiliate. Fairview, a system of six hospitals and 21 primary care clinics, and Ebenezer, which owns and manages nursing homes and

senior housing facilities, plan to join forces to improve continuity and quality of care and reduce the cost of care for patients in their combined systems. Both organizations plan to work together to develop a new service network focusing on older adults and the chronically ill and their families.

The affiliation—not considered a merger or acquisition—will position Ebenezer as a company within Fairview, but it will retain a separate identity. The affiliation is expected to be complete this spring.

PreferredOne CISN Approved

PreferredOne Community Health Plan received a Certificate of Authority from the Minnesota Department of Health in late January to conduct business as a community integrated service network. It has approval to conduct business in 45 counties throughout the metropolitan area and greater Minnesota.

Shortly after receiving approval to operate the CISN, PreferredOne Management Co. signed a letter of understanding with Fairview Physician Associates/Fairview Health System outlining goals and principles to guide the development of a partnership between the organizations. Fairview Physician Associates and Fairview Health System will be providing services as an integrated provider system in PreferredOne's CISN. Negotiations will be finalized over the next couple months.

AMC, BCBSM, HealthSystem Minnesota Announce Joint Venture

Affiliated Medical Centers (AMC) and Blue Cross and Blue Shield of Minnesota have signed a letter of intent with HealthSystem Minnesota to form a new joint venture to offer health care in west-central and southwestern Minnesota. The new venture formalizes a relationship that has existed since the 1970s between primary care physicians in the Willmar area and Park Nicollet Medical Center

specialists. To expand health care access, the groups plan to develop telemedicine technology so doctors in west-central and southwestern Minnesota can consult with Park Nicollet and Methodist Hospital specialists through videoconferencing.

Karlstad Hospital Closes

Just weeks after the Minnesota Hospital Association reported in January that 10 percent of Minnesota hospitals are ailing, Karlstad Memorial Hospital in northwestern Minnesota closed its doors. Twenty-eight Minnesota hospitals have closed since 1982.

Ironically, the hospital earned a small surplus in 1994 after years of losing money. It closed after two of Karlstad's three physicians left to practice elsewhere, prompting the departure of three nurses who felt uncertain about their job security. The town's third physician, Charles Mayo II, grandson of one of the founders of Mayo Clinic, will retire by September at age 65. Karlstad, a community of about 800, is trying to recruit another doctor and to develop cooperative health services with other towns and hospitals. Jeff Wanek, chief financial officer for Karlstad Health Facilities, which includes the hospital, a clinic, and a nursing home, said in a Minneapolis-based *Star Tribune* article that he is not optimistic that enough doctors and nurses can be recruited to reopen the hospital.

The Minnesota Hospital Association reported in January that although about 10 percent of the state's hospitals, primarily those in rural areas, are not doing well financially, the overall financial health of Minnesota hospitals has improved. The median operating margin among all Minnesota hospitals increased to 2.4 percent in 1993 from 1.3 percent in 1992.

The median margin dropped for the state's 22 large hospitals (those with 200 or more beds) to 4.2 percent in 1993 from 4.5 percent in 1992. The median margin for Minnesota's 81 small hospitals (fewer than 50 beds)

remained flat in both 1992 and 1993 at about one-tenth of 1 percent. The 43 mid-sized hospitals (between 50 and 199 beds) did the best; the median margin for the 25 hospitals with 50 to 99 beds rose from 3.5 percent to 3.9 percent in 1993. The margin for the 18 hospitals with 100 to 199 beds rose from 3.3 percent to 3.6 percent.

Growth in Health Care Costs Slows for Employers

Intensified competition in the health care marketplace combined with more effective managed care approaches to controlling costs are helping employers report an expected rate of health care cost increases of less than 2 percent for 1995, according to a survey by Towers Perrin. The survey found that the average reported cost increase from 1994 to 1995 for almost every type of health plan was less than 2 percent—down from 6 percent for 1993 and 1994. For all types of health plans except HMOs, the survey group reported 1995 average monthly costs of \$187 for employee-only coverage and \$517 for family coverage (employee plus two or more dependents), an increase of just over 1.6 percent from the levels reported for last year. By contrast, the overall U.S. inflation rate as measured by the consumer price index rose 2.6 percent from 1994 to 1995, while the medical component of the consumer price index rose 4.8 percent for the period.

The survey figures are based on preliminary premium cost data provided by employers to Towers Perrin's Employee Benefit Information Center. For self-insured plans, reported costs are premium equivalents, i.e., expected benefit and administrative costs. A total of 145 employers, primarily Fortune 1000 companies, participated in this year's survey.

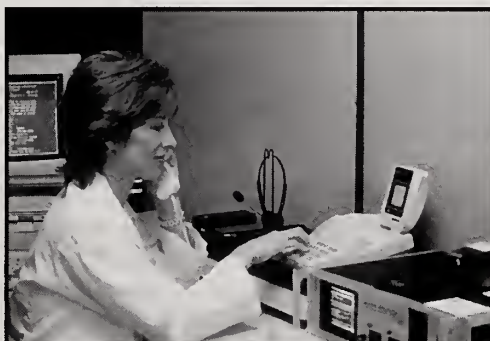
BCBSM Foundation to Endow Professorship

The Blue Cross and Blue Shield of Minnesota Foundation is giving

\$500,000 to the Institute for Health Services Research at the University of Minnesota School of Public Health to endow a professorship in health services research. It is the first endowment made by the BCBSM Foundation and the

first received by the institute. The University Foundation and the Institute of Health Services Research will provide additional support. The endowed chair will establish a sustained research and teaching effort at the university

Clinical Video Telemonitoring Keeps You Close To Your Patients



What You Can Expect From Us

Daily, or as-needed, routine & scheduled telemonitoring by trained nursing staff under the oversight of a physician, as well as emergency care response 24 hours a day, 7 days a week.

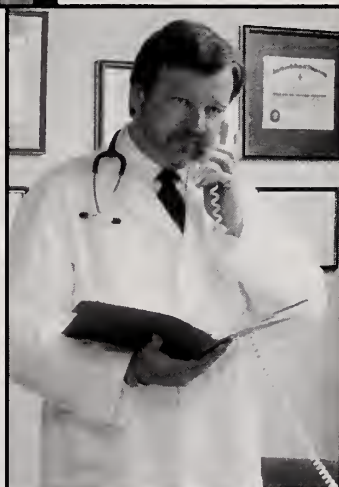
What Telemedicine Means For You

A new way to assist you in the care of your elderly, disabled, or post-operative patients, in their homes, by our trained nursing staff.

Systematic remote video assessment of your patients and their vital signs according to your orders.

Accurate instant information to you on your patient's clinical condition.

Customized and timely patient reports to your office.



What Telemedicine Means For Your Patient

Reduced costs compared to traditional long term care.

Full training on the easy to use video telemonitoring system.

Privacy, independence & security in the comfort of their own home.



For detailed brochure and additional information, call 612-897-0000. American TeleCare, Inc., 7680 Golden Triangle Dr., Eden Prairie, MN 55344-3732.

focused on health care financing and delivery. Among the topics being considered for research by the institute are methods to improve access to health services in rural areas, the effectiveness of alternative health care delivery systems, the effects of competition among health plans on health care costs, and the impact of insurance coverage on the utilization of health systems.

Innovations

..... Researchers Develop New Topical Anesthetic

Researchers at Children's Health Care—Minneapolis have developed a new topical anesthetic that is just as effective and less costly than the "gold standard" cocaine-based anesthetic. Results of research on the new topical anesthetic were published in the February issue of *The Annals of Emergency Medicine*.

Craig Schilling, Pharm.D., a clinical pharmacist at Children's—

Minneapolis, and Donald Uden, Pharm.D., formerly with Children's—Minneapolis and currently with the University of Minnesota College of Pharmacy, worked with physicians and nurses in the hospital's emergency department to develop the new anesthetic, composed of lidocaine, tetracaine, and epinephrine (the lidocaine replaces the cocaine). The study involved 171 children who were treated at Children's—Minneapolis for scalp and face lacerations over an 11-month period ending in 1993. Approximately 1,200 children have been treated using the new solution at Children's—Minneapolis since September 1993.

"Several concerns in using a highly concentrated cocaine-based anesthetic include the potential for adverse effects in patients, the cost of that solution, and the significant federal regulatory issues involved with dispensing and administering a cocaine-containing medication," said Schilling. "What we've developed is a safe, effective, and inexpensive alternative to the

cocaine-based solution." The new anesthetic is about one-twentieth the cost of the cocaine-based solution.

'U' Researcher Testing 'Smart Bomb' Against Leukemia

Researchers at the University of Minnesota have developed a "smart bomb" that attacks and kills leukemia cells without damaging normal cells. The treatment has been tested on mice and may be tested on humans this summer.

The smart bomb consists of an antibody that attaches to a receptor molecule found only on the surface of leukemia cells; attached to the antibody is a chemical called genistein, which kills the leukemia cell. "Normal tissue is not affected," said University of Minnesota researcher F.M. Uckun, M.D., Ph.D., in an Associated Press article in the Minneapolis-based *Star Tribune*. The technique can also be used for some cancers of the breast, ovaries, and brain, said Uckun, lead author of a report on the study published in the February 10 *Science*.

Tonsils May Show AIDS Progression

Keith Henry, M.D., of St. Paul-Ramsey Medical Center and colleagues at the University of Minnesota have discovered that small pieces of tissue from the tonsils of some AIDS patients can help physicians monitor and learn about progression of the disease. Henry described the group's findings at the second national AIDS research meeting in Washington, D.C., in late January. Researchers hope the technique will help doctors select the best dosages of AIDS-fighting drugs based on how active the virus is in a patient's body, and they hope it will give insight into how HIV grows. HIV is typically monitored using a blood sample, but recent research found that HIV often grows earlier and faster in patients' lymph tissue.

MM



**Hands
are not
for hitting.**

Domestic violence is preventable.

If someone is hurting you, call: 612/646-0994



Created by the Minnesota Coalition for Battered Women - 612/646-6177 V/TDD.

MMA

Merrill, Wisconsin Family Practice

When you join a practice in Merrill, Wisconsin, you'll be close to what is important to you: your practice, and your family.

A practice in Merrill, Wisconsin, means you're in the middle of safe, thriving areas offering diverse commercial interests, cultural variety, all-season recreation, and highly-rated school systems. You will receive a wide range of benefits including an excellent compensation package while practicing in a smaller, personalized environment.

We offer a lot and would like to also tell you what we don't offer: high cost of living, pollution, crime, congestion, and traffic.

For more information on practices in Merrill, Wisconsin, please contact:

Sam Holte, 1-800-766-7765.

FAX: (715) 847-2984.

Wausau Regional Health-care, Inc., 3000 Westhill Dr., Suite 202, Wausau, Wisconsin 54401.



Wausau Regional Health Care, Inc.
Divisions: Medical Clinic • Medical Family Clinic

AIM HIGH

CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle, quality practice
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF



CONTINUING MEDICAL EDUCATION

ST. PAUL - RAMSEY MEDICAL CENTER

Winter/Spring Schedule of Courses

Mark your calendar now for these upcoming conferences:

1995

March 9-10 Family Medicine Today, St. Paul

March 17 Occupational Medicine Update, St. Paul

March 24 HIV Primary Care Conference, Bloomington

March 30-31 Critical Care 1995: Practical Approaches & Case Discussions, St. Paul

April 6-7 Obstetrics & Gynecology Update, St. Paul

April 7 ENT Update, St. Paul

October 26-27 Trauma Management for Primary Care Providers, St. Paul

November 16-18 Primary Care Medicine, St. Paul

December 7-9 Cardiopulmonary Medicine, St. Paul

Information and registration:

Continuing Medical Education, St. Paul - Ramsey Medical Center,
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992, Fax 612/292-4773

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MARCH 1995

Mar. 6-10 **Medical Update 1995** University of Minnesota/Continuing Medical Education; Holy Cross Hospital, Fort Lauderdale, FL. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Mar. 9 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-10 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 13-17 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Mar. 17 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 19-24 **Brain to Pelvis** University of Minnesota CME; Beaver Creek Resort, Avon, CO. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Mar. 24 **Eleventh Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Mar. 24-26 **Advances in Clinical Anesthesiology** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 27-31 **Team Management of Diabetes Mellitus** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Cindy Poppitz, International Diabetes Center, 5000 West 39th Street, Minneapolis, MN 55416; 612/927-3393.

Mar. 30 **Tenth Annual Health Care Public Policy Conference: The Role of Academic Health Centers in the Evolving Health Care System** University of Minnesota; Sheraton Inn Midway, St. Paul, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 30-31 **Critical Care 1995** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 31 **John I. Coe Symposium** Hennepin County Medical Center; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Ann Samways, HCMC/HFA Office of Academic Affairs, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415-1829; 612/347-2078; or Robin Hoppenrath, 612/337-7128.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

MARCH 1995

Mar. 11 **Infectious Diseases** Group Health Foundation; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Debbie Beadine, 8100 30th Avenue South, Bloomington, MN 55425; 612/883-5341.

Mar. 24 **The Primary Care of HIV 1995** Allina; Holiday Inn International, Bloomington, MN. CONTACT: Don Young, Allina, 2810 57th Avenue North, Suite 425, Minneapolis, MN 55430; 612/574-7982.

APRIL 1995

Apr. 12 **Infectious Disease Update/TB/Hepatitis/HIV** St. Joseph's Medical Center; St. Joseph's Medical Center, Brainerd, MN. CONTACT: S.J. Bode, Resource Coordinator, 523 North 3rd Street, Brainerd, MN 56401-3098; 218/828-7414.

MAY 1995

May 5-6 **Common Infections of Mothers and Infants—Prevention and Management** Children's Health Care, Minneapolis/St. Paul; St. James Hotel, Red Wing, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-5884.

A P R I L 1 9 9 5

Apr. 6-7 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 6-7 **Fifteenth Annual Pediatric Update** Dakota Medical Center; Doublewood Inn, Fargo, ND. CONTACT: Deb Clemenson, Dakota Hospital, 1720 South University Street, Fargo, ND 58103; 701/280-4546.

Apr. 6-9 **Second International Conference on the Medical Aspects of Telemedicine and Second Annual Mayo Telemedicine Symposium** Mayo Foundation, World Health Organization, and the Agency for Health Care Policy and Research; Rochester, MN, Scottsdale, AZ, and Jacksonville, FL. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 7 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 8 **Problems in Clinical Anesthesia—Department of Anesthesiology Clinical Symposium** University of Minnesota Anesthesiology Department; Radisson Metrodome, Minneapolis, MN. CONTACT: David S. Beebe, M.D., Box

294, B515 Mayo, Department of Anesthesiology, 420 Delaware Street SE, Minneapolis, MN 55455; 612/624-9990.

Apr. 9-12 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 28 **Allergy and Clinical Immunology** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Apr. 28-29 **Minnesota Orthopaedic Society Eleventh Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

M A Y 1 9 9 5

May 1-5 **Family Practice Review and Update** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

The logo features the words "EAST METRO" in a small box above "Community Health" in a large, stylized script font, which is above "NETWORK" in a small box.

Nurse Practitioner

The East Metro Community Health Network has full and part-time openings for a Nurse Practitioner in Adult or Family Medicine. The ideal candidate will have an interest in working with low-income/minority populations. Must be a graduate of an accredited program and licensed to practice in Minnesota. Attractive hours, salary, benefits. Interested applicants send resume to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

PHYSICIAN WANTED

Community Care for the Elderly is looking for a board certified internist or family practitioner with an interest in the care of the elderly. The position offers a position to care for the frail elderly of the community in an adult health care center and clinic. An understanding of the elderly and the ability to work with a multidisciplinary team is needed. The positions available are for part-time and full-time practice. Interested individuals should contact:

Mary Gavinski, M.D., Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
414-536-2110, ext. 254

Your Future is Our Future

Join the newest member of the Fairview family - Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, our organization has joined the Fairview Health System.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Practice
Internal Medicine

OB/GYN
Urgent Care

CHISAGO HEALTH SERVICES



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469



Quality Medicine Quality Community

Heartland Family Practice is a six physician group located in thriving St. Cloud, Minnesota. As part of this progressive group, you will practice in a newly constructed clinic just one-half mile from St. Cloud Hospital.

St. Cloud is Minnesota's fastest growing area, conveniently located between the Twin Cities and prime Minnesota lake regions. Enjoy our family oriented community with its university atmosphere and excellent recreational offerings.

Please send CV or call:

John Schnettler
Physician Recruiter
St. Cloud Hospital
1406 6th Avenue North
St. Cloud, MN 56303
800-835-6652

Heartland
FAMILY PRACTICE

URGENT CARE OPPORTUNITIES **Group Health, Inc.**

Group Health, Inc. is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24 hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, or 1-800-472-4695, or send CV to: **Group Health, Inc.**, Physician Services, Attn: Ann Johnson, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



*Group Health is part of the
HealthPartners family of health plans.*

EO/AA Employer



HealthPartners

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., March 15 for May ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine, Physicians Assistant to join progressive 11-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician,

multispecialty practice located just south of the Twin Cities on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Stillwater: 20-physician multispecialty group with emphasis on primary care seeking BC/BE family physician. Scenic location with excellent school system, supportive medical community with strong local hospital, competitive salary and benefits. Send CV to Jon Pedersen, St. Croix Valley Clinic, 921 South Greeley, Stillwater, MN 55082; 612/439-2215. (9/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)



Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)

*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Urgent Care Physicians: Immediate part/full-time positions available at new Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 20-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612.763.5123

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/ Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Donald Weinshenker, M.D.
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (* 5/92-R)

Internal Medicine—Carroll, Iowa: Outstanding opportunity for an internal medicine physician in a progressive, safe, and clean community of 10,000 located in west-central Iowa, 90 miles from Des Moines, Iowa, or Omaha, Nebraska. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 square-foot outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, St. Anthony Regional Hospital, 800/382-4197. *6-4/95

Primary Care Physicians and Subspecialists are being sought for a variety of group practices located throughout the upper Midwest and New York state. Choose from metropolitan cities, college towns, popular resort communities, or traditional rural destinations. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology, and nephrology. New opportunities monthly! For all of the facts, call 800/243-4353, or write to: Strelcheck and Associates, 10624 North Port Washington Road, Mequon, WI 53092. *3-4/95

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-5237 MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.

Urgent Care

Additional full-time BC primary care physician needed to join our UrgentCare Clinic for expanding hours of service. Join our collegial team of physicians and support staff in a position offering a competitive salary and comprehensive benefits. Weekday and weekend schedules.

For more information, contact:

Linda Basara, Director
Physician Placement
St. Luke's Hospital
915 East First Street • Duluth, MN 55805
1-800-321-3790
(218) 726-5356

St. Luke's
MEDICAL CLINIC

LaCrosse, Wisconsin

- Live in beautiful Mississippi River Valley.
- Work with high quality colleagues in growing multispecialty group (70 Physicians).
- Competitive income/benefits.

Specialists Needed

Cardiology (Non-Invasive)
Critical Care/Pulmonary Medicine
Dermatology
Emergency Medicine
Family Practice
Internal Medicine
Neurology
Occupational Medicine
Orthopedic Surgery
Pediatrics
Urology

Send CV to:

P. Stephen Shultz, M.D.
SKEMP CLINIC
800 West Avenue South
La Crosse, WI 54601
Fax (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329



Columbia Park Medical Group

- OB/GYN ● BC/BE Specialists
- Family Practice ● Internal Medicine

OB/GYN:

Three BC Physicians are looking for a fourth to join in their busy practice.

FAMILY PRACTICE: Join group or do locum tenens. Join 27-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE:

Seven-member department has busy hospital and clinic practice.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered.

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Kay Duffney
(612) 586-5876

Family Practice, Minneapolis: BC/BE family practice physicians needed to join the family practice department of a 385-physician multispecialty clinic in desirable Twin Cities area. Currently, we have positions available at our Shakopee and Prior Lake offices. Salary and benefits are highly competitive. For additional information, contact Patrick Moylan at 612/993-3286, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; Fax: 612/993-2819. *2-3/95

Mork Clinic, P.A.—Anoka, Minnesota: BC/BE obstetrician/gynecologist needed to join growing physician-owned, primary care, multispecialty, seven-physician clinic. Two well-equipped offices in Anoka and Elk River. Utilization of one hospital. Excellent professional opportunity with ample time to enjoy family life. Contact Curt Keller, M.D., Mork Clinic, P.A., 1833 Second Avenue South, Anoka, MN 55303. *3-3/95

Southwestern Montana: Position for psychiatrist on a 20-bed acute-care unit (average length of stay 40 days). Join the six psychiatrists serving this 200-bed state hospital. Excellent outdoor opportunities. Mountains surround the area. Excellent skiing, hunting, fishing, and hiking. Trout stream less than one mile from hospital. Salary \$90,291-\$104,500 based on experience. Send CV or inquiries to Carl L. Keener, M.D., Medical Director, Montana State Hospital, Warm Springs, MT 59756; 406/693-7008. EOE. *1-3/95

Physician Internist

The St. Cloud, Minnesota VA Medical Center is a dynamic 556-bed facility providing excellent psychiatric and intermediate care to veterans.

An exceptional opportunity exists for a physician board certified in Internal Medicine with an interest in doing primary care and general internal medicine consultations. We offer competitive salary and benefits combined with a stable 40-hour weekly schedule.

To explore this unique opportunity, call or write:

Thomas Plombon, Human Resources Management Service 612-255-6301 or
Dr. Susan Markstrom, Acting Chief, Medical Service 612-255-6371
VA Medical Center
4801 N. 8th Street
St. Cloud, MN 56303

La Crosse, Wisconsin

BC/BE general pediatrician to join four pediatricians in growing multispecialty group (70 physicians). Competitive guaranteed income/benefits. Affiliation with local hospital system and major medical center expected. Desirable midwestern, small city in beautiful Mississippi River Valley. Great family atmosphere, excellent schools and recreation opportunities.

Send CV to:

P. Stephen Shultz, M.D.
SKEMP CLINIC
800 West Avenue South
La Crosse, WI 54601
Fax (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physician Services, 2810 57th Avenue North, Minneapolis, MN 55430; 800/248-4921 or 612/574-7627. *3-3/95

BC Family Physician to join high-quality, 17-M.D., single-specialty family practice group. Four sites in the Minneapolis northwest metro area. Very reasonable lifestyle with competitive salary and benefits. Contact Jamie Peters, M.D., Northwest Family Physicians, 1495 State Highway 101 North, Plymouth, MN 55447; 612/476-6776. *3-3/95

Medical Director: Part-time board-certified primary care physician. Western Wisconsin insurance company/TPA. Medical advisement for appropriateness reviews/managed care products. Résumé to: Midwest Security Insurance Companies, HR Manager, 2700 Midwest Drive, Onalaska, WI 54650. *1-3/95

Mankato Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our outpatient family practice clinics. Attractive compensation and benefits package. Contact Cara Auge, c/o NOW Care Medical Centers, 1970 Rahn Cliff Court, Eagan, MN 55122; 612/686-6442. 1-3/95

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Family Practice	Pediatrics
Internal Medicine	Neurology
Orthopedic Surgery	OB/GYN
Noninvasive Cardiology	Urology

Send your CV to Gary Luiten, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/862-9012.

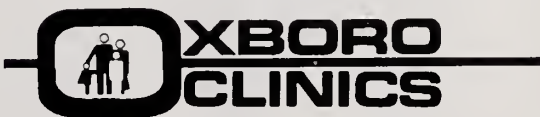
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
(612) 885-6224 or toll free 1-800-842-6469

OUR HIGH GROWTH LOCALE Means Expanding Opportunity

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

Occupational Medicine—Minneapolis: BC/BE occupational medicine physician needed to join Occupational Health-System Minnesota of Park Nicollet Medical Center. We are a 385-physician multispecialty clinic in the desirable Twin Cities area. Physicians that are BC/BE in family practice or internal medicine, with experience or strong interest in occupational medicine, are also encouraged to apply. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at 612/993-3286, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; or Fax, 612/993-2819. *2-4/95

Family Practice/General Surgeon/Pediatrician, BC/BE, to join progressive 26-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. *3-5/95

PHO Medical Director: Developing PHO in Western Washington has an exciting opportunity for a creatively oriented primary care physician to be our medical director. If you have experience guiding a start-up physician group into

managed care, including utilization management, quality assurance, outcomes management, and health plan capitation contracts, then we'd like to talk with you. The PHO is in partnership with 225-bed Good Samaritan Hospital, ideally situated between skiing and boating, 30 miles south of Seattle. We offer excellent benefits, minimum salary of \$150,000. Send CV, letter of introduction, and desired salary to Medical Director Application, Puyallup Valley Healthcare, PO box 1247, Puyallup, WA 98371-0192. Application deadline is March 31, 1995. *1-3/95

MARCH 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
American TeleCare Inc.	53
Army Reserve	18
Aspen Medical Group.....	49
C.F. Anderson Co., Inc.	17, 41
Central Minnesota Group Health Plan	41
Chisago Health Services.....	58
Columbia Hospital	30
Columbia Park Medical Group	62
Community Care Organization	57
Comprehensive Medical Care	63
Duluth Clinic	23
East Metro Community Health Network	31, 57
Fairview Clinic Services	51
Fargo Clinic MeritCare	18
Gillette Children's Hospital	31
Global Holidays	32
HealthPartners	24, 58
Hennepin Faculty Associates	Cover 3
LPL Financial Services	3
Mankato State University	61
Medical Protective Company	Cover 2
Minnesota Medical Business Resources	Cover 4
Minnesota Physicians Insurance Agency	49
Moonlight Home Health Care	60
Multicare Associates of the Twin Cities	49
North Memorial Medical Center	17
Oxboro Clinics	63
Ramsey Clinic	64
Refreshment Committee	24
River Valley Medical Center	31
Skemp Clinic	61, 62
St. Cloud Hospital	58
St. Francis, Inc.	63
St. Luke's Hospital	61
St. Luke's Midland Regional Medical Center	41
St. Paul-Ramsey CME	55
Stutzman-Helling	24
U.S. Air Force Health Professionals	55
Veterans Administration Medical Center	60
Veterans Affairs Medical Center	62
Wausau Medical Center	55
Whitesell Medical Locums, Ltd.	29

Family Practice Opportunity at the Family Medical Clinic in Amery, Wisconsin

Come join a dynamic ten-physician primary care practice and live in Wisconsin's beautiful lake country.

Affiliated with Ramsey Clinic, a large multi-specialty group practice, and the St. Paul-Ramsey Medical Center, a leading tertiary care center, physicians have access to immediate consultations, helicopter support, research and teaching opportunities and financial security.

Amery is a charming community of 2800, sprinkled with lakes and rivers, and located within an hour of the Twin Cities. Physicians have never left, only retired.

Please contact Aynaley Smith at Ramsey Clinic
Department of Professional Services
640 Jackson Street
St. Paul, Minnesota 55101
or by phone at 612-221-4230
or via facsimile at 612-221-8571

Ramsey Clinic



CME ACTIVITIES

Sponsored by the University of Minnesota and Hennepin County Medical Center.

Programs are designed for physicians' continuing education credit
and other specialty education credit.

HIV
PRIMARY CARE
CONFERENCE



MARCH 24, 1995

HIV Primary Care Conference

Primary Audience:

Primary Care Physicians, Allied health care providers

March 24, 1995

Holiday Inn International, Bloomington

Chair: Hanan Rosenstein, MD, Abbott Northwestern Hospital

This conference is designed to address management and
medication issues for your patients with HIV • 7.0 Credits

Research Statistics: A Two-Day Primer



Research Statistics: A Two-Day Primer

Primary Audience:

All interested physicians (limited attendance)

March 23, 1995

Chair: Alfred Pheley, PhD, HCMC

Hennepin County Medical Center, Minneapolis

11.25 Credits

Annual John I. Coe Symposium • March 31, 1995

Held in conjunction with the Annual MSP Meeting on April 1, 1995

Primary Audience: Pathologists and Clinicians • Hennepin County Medical Center, Minneapolis

Program Co-Chairs: Fred Apple, PhD, HCMC – James Hernandez, MD, St. Cloud Hospital

The program this year will focus on thyroid testing • 9.75 credits

LAUP (Laser Assisted Uvulo-Palatoplasty) Conference • April 21, 1995

This program will offer techniques, tips and long-term results of LAUP

Primary Audience: Otolaryngologists and Surgeons • Hennepin County Medical Center, Minneapolis

Program Chair: Robert Maisel, MD, HCMC • Approximately 8.0 credits

Phonosurgery: Indications and Techniques • May 19-20, 1995

Hands-on workshop limited to 32 participants

Primary Audience: Otolaryngologists and Speech Pathologists • Hennepin County Medical Center, Minneapolis

Program Chair: George Goding, MD, HCMC • 15.0 credits

Advanced Life Support in Obstetrics (ALSO) • August 18-19, 1995

Primary Audience: Primary care physicians • Mall of America Grand Hotel, Bloomington • Program Chair: Vicki Short, MD, HCMC

*This program is designed to assist health professionals in developing and maintaining the knowledge and skills they will need to effectively
manage the emergencies that arise in Obstetrics • Approximately 14.0 credits*

For registration/brochure/or more information:

Ann Samways or Robin Hoppenrath

HCMC Office of Academic Affairs • 701 Park Ave., Mail Code 869-A • Minneapolis, MN 55415 • (612) 347-2075, FAX (612) 347-2154

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HCMS*

**To apply, call:
1-800-298-MMBR (6627)**

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

Health reform bills
advance, see page 33



12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Professionals
Pittsburgh, PA 15261-0001

Approximately 90% of young adults begin smoking before the age of 20. Those who don't smoke before they are 20 are unlikely ever to smoke. As a result, 90% of the adult smokers in this country are young adults. Therefore, we respectfully urge you to follow the measures in your legislation and propose that they be enacted immediately pending your

Minnesota aims to
NUFF OUT SMOKING

APRIL 1995

APR 13 1995

Members of the Minnesota Medical Association are saving money on their workers' compensation insurance premium costs with the Dodson Plan!

Minnesota Medical professionals were paid a 10% dividend totaling \$128,304.91 in 1995!

Because dividends depend in part on claim costs and related expenses, they can't be guaranteed. However, *participating members have been paid dividends 19 out of 23 years!*

In addition to yearly dividend opportunities, MMA members receive:

Personalized Service. Our home office and field staffs are experienced and professional. They work closely with you, addressing your questions and concerns.

Loss Control Assistance. Field representatives are available to suggest programs that could help reduce the severity and frequency of workplace accidents.

Flexible Premium Payment Plan. The Plan is designed to give you flexibility in paying your insurance premiums with interest-free installments!



DODSON GROUP
9201 State Line Road
Kansas City, MO 64114

Get the Facts!

Dodson Group insured its first customer in 1900 and its first MMA member in 1972! Today, we're putting that experience to work for you with progressive insurance programs and exceptional service!

MMA members can receive a free no-obligation premium quote . . . just call or FAX Dodson today!

CALL: 1-800-825-9489

FAX: 1-800-825-6035

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Gwendolyn Wong.

DEPARTMENTS

5 EDITOR'S NOTEBOOK

51 NEWS CLIPS

56 CME IN MINNESOTA

59 CLASSIFIED ADS

64 INDEX TO ADVERTISERS

MAURICE AND LAURA FALK LIBRARY
OF THE HEALTH SCIENCES
UNIVERSITY OF PITTSBURGH

APR 19 1995

FACE TO FACE

- 6 THE HOUSE PHYSICIAN** Fran Miller Toubin
Family practitioner-turned-lawmaker Richard Mulder is still treating rural health care needs—from the Capitol.

COVER STORY

- 10 COMMUNITIES TAKE AIM TO SNUFF OUT SMOKING** Miriam K. Feldman
Minnesota's anti-smoking initiatives fire up, despite pressure from the tobacco industry.

PUBLIC HEALTH REPORT

- 19 THE ECONOMIC AND HUMAN COSTS OF SMOKING IN MINNESOTA** ... Dick Welch, Ed.S., Kathy Daly, Ph.D., and Judith Hilton
One in six Minnesotans die a smoking-related death, leading to economic costs of more than \$1 billion annually—losses that can be prevented in part through public policy initiatives.

MEDICINE LAW & POLICY

- 23 INDUSTRY UNDER FIRE: MINNESOTA V. THE TOBACCO INDUSTRY** Hubert H. Humphrey III
Seeking to recover millions of dollars spent on tobacco-related health care costs annually, the state is suing the tobacco industry for consumer fraud and antitrust conspiracy.

CLINICAL AND HEALTH AFFAIRS

- 28 CERVICAL RADICULOPATHY: CAUSES AND SURGICAL TREATMENT** Michael D. Smith, M.D.

EDITORIAL

- 46 IMPROVEMENTS IN DIABETES TREATMENT** Bruce R. Zimmerman, M.D.
A Minnesota clinician and researcher comments on recent achievements in upgrading diabetes therapy.

The Monitor

HIGHLIGHTS MMA advances Quality and Coverage Act goals
• AMA president-elect calls for cultural competence • MMA testifies against chiropractic bill

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.

President-Elect
Michael J. Murray, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Ophelia Balcos

Board of Trustees

N.W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legal Affairs
Mary E. Prentnieks, J.D.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

Where knowledge and practice interact



CONTINUING MEDICAL EDUCATION

Continuing Education and Extension, University of Minnesota

Selected Courses 1995

**Common Cardiac Arrhythmias:
Recognition and Treatment**
April 21 • Minneapolis

**Allergy and Clinical
Immunology**
April 28 • Minneapolis

**Family Practice
Review & Update**
May 1-5 • Minneapolis

**Annual Ophthalmology Course:
The Eye of the Child**
May 5-6 • Minneapolis

**Women's Cancer Center
Symposium: Gynecology &
Gynecologic Oncology**
May 9 • Minneapolis

**Current Concepts in Radiation
Therapy**
May 10-12 • Minneapolis

**Temporal Bone Dissection &
Endoscopic Ear Surgery**
May 18-20 • Minneapolis

**Evaluation and Management of
Peripheral Vascular Diseases**
May 20-21 • Minneapolis

Emerging Infections
May 31 • Minneapolis

**Clinical Hypnosis: Introductory
and Advanced Workshops**
June 1-3 • St. Paul

Topics & Advances in Pediatrics
June 14-16 • Minneapolis

**Advances in Breast and Cancer
Surgery**
June 26-28 • Minneapolis

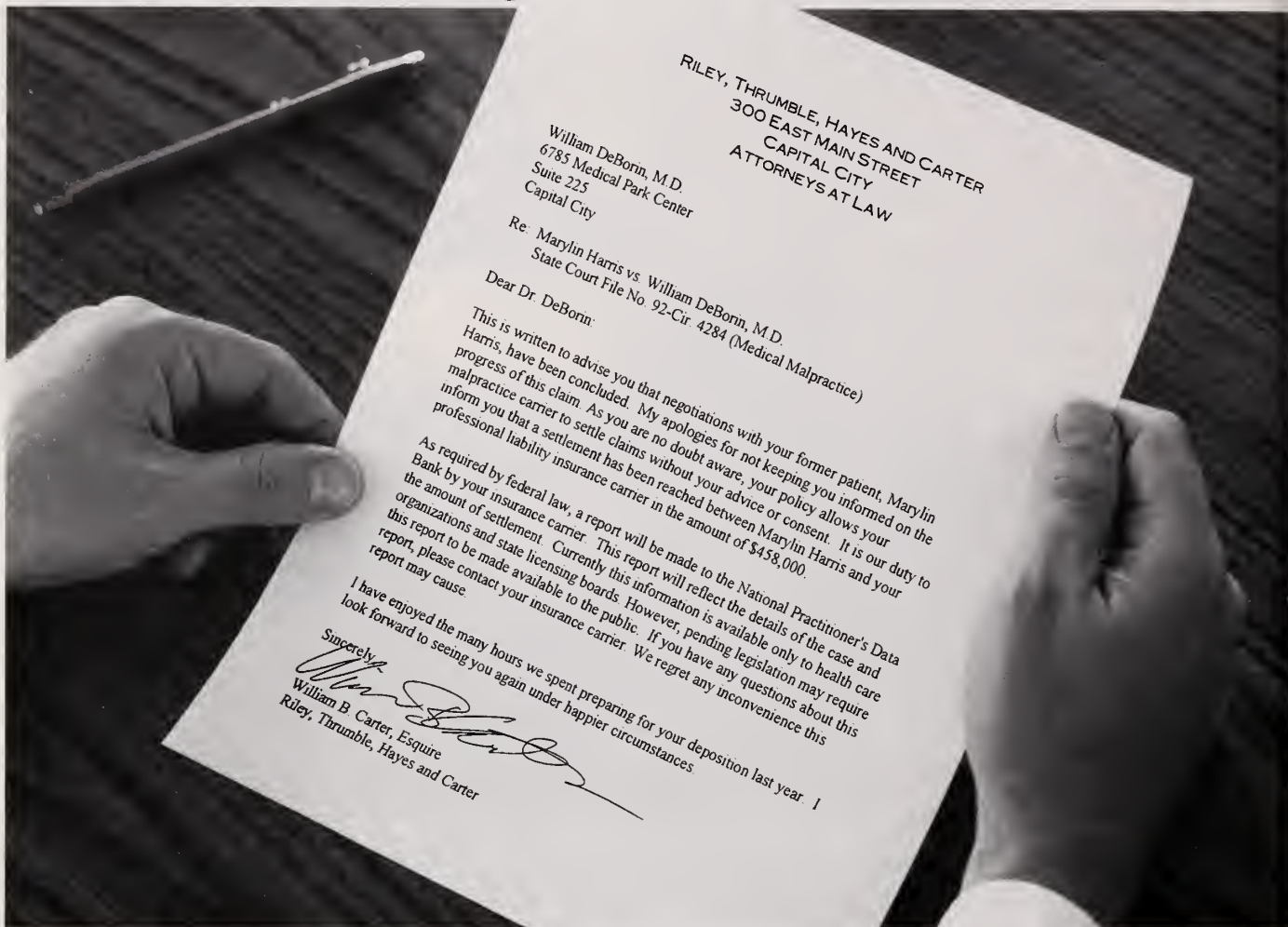
**Advances & Controversies in
Critical Care**
July 7-8 • St. Paul

**Minneapolis Transplant
Congress: New
Immunosuppressive Drugs**
August 27-30 • Minneapolis

Internal Medicine Review
October 18-20 • Minneapolis

**Obstetrics & Gynecology
Annual Autumn Seminar**
October 26-27 • Minneapolis

Medical Protective Policyowners **NEVER** get letters like this!



Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

THE **MEDICAL PROTECTIVE COMPANY** FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's

800/344-1899



An Infernal Habit

Charles R. Meyer, M.D.

He who lives without tobacco is not worthy to live.

—Molière

A custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black stinking fumes thereof, nearest resembling the horrible Stygian smoke of the pit that is bottomless.

—King James I



“Since cigarette smoking was linked to lung cancer in 1964, medicine has presented an increasingly insistent anti-tobacco front.”

stating that “only the fanatic ... would condemn all smoking.”

To be kind to our medical forebears, I would label this era of medicine and tobacco the “Age of Uncertainty”—a time when the scientific evidence was not sufficiently compelling to publicly challenge the political power and financial muscle of the tobacco industry. That changed in 1964, when Surgeon General Dr. Luther Terry issued his report linking cigarette smoking to lung cancer. Medicine has since presented an increasingly insistent anti-tobacco front.

This “Scientific Age” has witnessed the relentless documentation of tobacco’s direct health consequences and the recognition of secondhand smoke’s hazards. Scientific challenges to the tobacco industry’s pseudoscience continue to gain ground. The percentage of American smokers has halved since 1962. Congress and the courts called for the first health warn-

ings on cigarette packs in 1972. And, most important, smoking-attributable deaths have declined.

But, as our Public Health Report reveals, the trend is not all favorable. Despite intensive public health efforts to curb smoking, about 22 percent of Minnesotans continue to light up. Enter the third era of medicine and tobacco, “The Legal Age,” which is the primary focus of this month’s *Minnesota Medicine*. Minnesota Attorney General Hubert Humphrey describes the state’s current lawsuit challenging the tobacco companies on their commercial conduct, and he briefly summarizes legal challenges underway elsewhere. Our cover story chronicles community initiatives to restrict youth access to tobacco.

What has moved the dialogue from the research lab to the courtroom? The rise of “The Legal Age” stems partly from the tobacco industry’s successful recruitment of teen smokers; partly from society’s realization that smoking is not just an individual decision but an act that affects us all through secondhand smoke and rising health care costs; and, perhaps most painfully, from the senselessness of untreatable, preventable illnesses caused by a product sanctioned by society.

We are improving. A majority of our society today agrees with King James. Fewer people agree with Fran Lebowitz that “Smoking is ... the entire point of being an adult.” Risking a polarization of smokers and nonsmokers, in growing numbers we are likely to stand with Ben Jonson, who said that smoking is “good for nothing but to choke a man, and fill him full of smoke and embers.” Perhaps the force of science and law will convince the uncertain, unlock the shackled, and clean up the remaining Stygian soot.

MM

THE HOUSE PHYSICIAN

Dr. Richard Mulder's campaign strategy in the race for Minnesota state representative last November didn't include holding all the babies in his district. As a family practitioner in Ivanhoe

for the past 25 years, he actually delivered many of them—as well as some of their parents. So he concentrated instead on familiarizing the voters in his 3,000-square-mile district that borders on Iowa and South Dakota with his views, his steadfast commitment to the people of rural Minnesota, and his record of effecting change for the better. The result: he handily defeated the Democratic incumbent.

Mulder, who prefers less government and abhors the notion of career politicians ("Many have never held a real

job"), has proven he can successfully implement change within and without government. Holding a bachelor's degree in pharmacy from South Dakota State University in Brookings and an M.D. from the University of Iowa, Mulder set up a solo practice in Ivanhoe, Minnesota, where one of his first tasks was establishing an immunization program for schoolchildren. In 1972, his county became the first in the state to guarantee 100 percent immunization, and, Mulder is quick to point out, this was accomplished without federal or state funds.

Currently the only physician in Minnesota's House of Representatives, Mulder hopes to use his two-year term to educate his fellow lawmakers about what he believes is a deteriorating quality of life in rural Minnesota. Although Mulder campaigned on many issues and is actively involved in community and religious affairs, it is health care—rural health care, in particular—about which he is most vocal and passionate. His many health care-related endeavors include holding numerous positions with the Minnesota Medical Association and the Minne-

BY FRAN MILLER TOUBIN

PHOTOGRAPH BY BRUCE BAIRD



Family practitioner-turned-lawmaker Richard Mulder is still treating rural health care needs—from the Capitol.

sota Academy of Family Physicians and appointments to the Minnesota Board of Medical Practice and the Department of Human Services Drug Utilization Review Board.

Although his new role keeps him busy, Mulder says, "I'm not under nearly as much pressure and the work is not nearly as strenuous as being a 24-hour on-call solo practitioner. There are no life-and-death decisions, and when I go back to the apartment at 7 or 8, I can relax."

Because they don't particularly like living in the city, Mulder and his wife, Ruth, who was his campaign manager and continues to assist him with scheduling and correspondence, travel back to Ivanhoe on weekends. (They fly a 1968 Cessna. "It costs less than my car and runs on less than my pick-up," says Mulder, who has been a licensed pilot for the past 25 years.)

With a self-described high energy level and the ability to delegate, Mulder maintained 80 percent of his practice during the campaign, but he now leaves it to two full-time physician assistants, a full-time hospital physician, and two part-time locum tenens physicians. Mulder says these health care professionals, as well as physicians in surrounding towns, "help me maintain my practice because they, along with my patients, know the importance of my being up here."

Mulder calls his office daily to check on patients. He doesn't believe he's lost any business as a result of being away. "As a solo practitioner, you have to be well-organized and have systems in place, since you can't be in two places at once. I feel like the conductor of an orchestra whose members are being asked to play a few bars on their own. So far, it's working, and I'll be back full time when the session ends in May."

A proponent of term limits, Mulder says he'll never give up medicine for politics. "It's important after creating laws and programs to go out there and see how they really work." Mulder, himself, is particularly familiar with the workings—and shortcomings—of the Medicare program. In 1987, after informally studying the problems surrounding rural health care for several years, he accepted a Bush Fellowship, which enabled him to further research the reasons for reduced access to quality health care in rural Minnesota. He discovered that reduced access to health care was a national problem, especially for senior citizens,

and that at the root of this problem was inadequate and unequal Medicare reimbursement in rural areas.

Mulder backed up his claim with Health Care Financing Administration data that showed costs of health care and reimbursement levels by county. In Minnesota, the situation was particularly grim, with reimbursement for seniors (who were paying the same federal taxes and premiums as those in other areas) at about 40 percent of the national average. And, in rural Minnesota, reimbursement levels were lower still, forcing doctors and hospitals in some areas to close their doors.

First at the county and state medical society levels and then through the American Medical Association and the American Academy of Family Physicians, where he was appointed to the National Rural Health Care Task Force, Mulder worked to get resolutions passed to remedy the unjust situation in which seniors in some areas of the country essentially subsidized health care for seniors in other areas.

On the national level, Mulder worked closely with Sen. Dave Durenberger and Rep. Vin Weber and made more than 30 trips to Washington, D.C., contacting every member of Congress. Finally, in November 1990, the Resource-Based Relative Value Scale was passed, a fee schedule that, for the first time, eliminated some of the health care reimbursement inequities for rural seniors.

Although this legislation has almost equalized Medicare reimbursement, Mulder says there is still much to be done. He says that the very same situation—providers being reimbursed inequitably—is occurring in Minnesota with Medical Assistance. "In addition," says Mulder, "ISNs and HMOs are doing deals with insurance companies who, as a result of these discounts, are shifting their costs to rural citizens. Now what we're seeing is rural Minnesotans paying higher premiums than the average in the Twin Cities. And that's just not fair—especially since the cost of health care is less in rural Minnesota."

Mulder also believes that the 2 percent provider tax created under MinnesotaCare is especially hard on border towns, whose doctors, hospitals, and pharmacies are losing patients and customers to neighboring states. As a member of the MMA Board of Trustees and House of Delegates, Mulder has been involved in drafting legislation the MMA recently

submitted to the Legislature that, among other changes, would replace the 2 percent tax with a tobacco tax and repeal RAPO (the regulated all-payer option).

While Mulder supports these and most aspects of the MMA legislation, he says he doesn't believe that plans for universal coverage and mandatory health insurance included in the bill are realistic. "We're probably at 93 percent [coverage] right now, which is higher than any other state," says Mulder. "By spending a tremendous amount of money, millions of dollars, we may get another 2 percent, but it's not worth it. And 100 percent just simply isn't possible. I do think we need to mandate programs that will create incentives to have everybody insured and create an environment where everyone will want to have health insurance."

As far as any ambition for higher political office, Mulder says he has no desire to move to the federal level and believes "the state is where all the action is." He believes it is wrong for physicians—and others, for that matter—to isolate themselves from the responsibility of government. Despite the fact that there is no financial incentive for physicians to hold elected office, he encourages his physician colleagues to get involved because, he

believes, they are in the best position to help direct health care policy that will ensure future access to quality care for their patients, as well as for their own families.

When Mulder is not practicing medicine, working on state policy, or spending time with his wife and kids, he enjoys visiting his mother in his hometown of Rock Valley, Iowa, researching genealogy, traveling, scuba diving, watching westerns and old movies, and flying.

As much as he enjoys his new venture into politics, he says if his four children were still at home, he would not have run for office: "It would have required too much time away from them." Although Mulder has enjoyed numerous successes, his daughter recently summarized his most treasured accomplishment by saying, "I don't know how you did it, Dad, but somehow you managed to have the best balance between your commitments to your patients and your family."

Balance and commitment. What more could Minnesota ask for in a legislator?

MM

Fran Miller Toubin is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

"It's important after creating laws and programs to go out there and see how they really work."

—RICHARD MULDER, M.D.

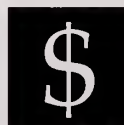
"MANAGED CARE SYSTEMS: EMERGING HEALTH ISSUES FROM AN ETHICS PERSPECTIVE"

June 1, 1995 • 8:00 am to 5:00 pm • Hyatt Regency Minneapolis

A full day conference devoted to examining the leading legal, ethical and medical issues emerging from managed care arrangements. The conference will feature nationally-recognized faculty who will facilitate interaction among participants.

PLENARY SESSION I

"The Fundamental Questions Raised by Managed Care Arrangements"



PLENARY SESSION III

"Managed Care and Health Care Purchasers"

PLENARY SESSION II

"Ethically Managing Health Care Services for Quality, Efficiency and Choice"



PLENARY SESSION IV

"Relations between Managed Care Organizations and Providers"

Presented by

**American Society of Law, Medicine & Ethics
The Medica Foundation**

Co-sponsored and accredited by

**Center for Biomedical Ethics
Department of Continuing Education
University of Minnesota**

For more information,
please contact:
American Society of Law,
Medicine & Ethics
Phone: (617) 262-4990;
Fax: (617) 437-7596.

**CNE, CLE,
and 7.0 CME
credits!**

FLEXIBLE COVERAGE FROM CNA:

Protection that meets the changing needs of your group practice.



At CNA, we tailor our medical group practice professional liability insurance to your specific needs now, and as your practice changes.

Our single policy form can accommodate all of your group coverage needs, including the addition of physicians and in-house services such as laboratories, pharmacies, diagnostic and surgery centers. It can also cover the expansion of your current facility or the addition of satellite locations. For larger groups, we offer various coverage options including limits of liability structures, self-insured retentions and loss sensitive premium plans.

For over 20 continuous years we've been helping group practices just like yours.

That's why you can count on us to cover your insurance needs now... and as they change.

For more information about medical group practice professional liability insurance from the CNA Insurance Companies, contact your local broker or:

The CNA Insurance Companies
Professional Liability Group, 19S
CNA Plaza
Chicago, IL 60685
(312)822-5000

CNA
MEDICAL
GROUP
PRACTICE
PROGRAM

CNA

For All the Commitments You Make®

Program underwritten by property/casualty companies of the CNA Insurance Companies. CNA is a registered service mark of the CNA Financial Corporation.

Communities Take Aim to Snuff Out Smoking

Minnesota's anti-smoking initiatives fire up, despite pressure from the tobacco industry.



By Miriam K. Feldman

When the Minnesota Department of Health released a report on smoking in early January, newspapers played up the cost angle. "Smoking's tab up 32 percent in Minnesota," proclaimed a *Pioneer Press* headline. "Health care costs tied to smoking rise," the *Star Tribune* reported. Buried beneath the headlines, however, was the real story: Minnesota's anti-smoking efforts have stalled out. Despite intense efforts to curb smoking in the state, our smoking rate has hovered around 22 percent since 1990. A 1991 jump to 23.3 percent placed us above the national average of 23 percent and knocked us out of first place in a Northwestern National Life Insurance Co. ranking of the nation's healthiest states.

These aren't the kind of figures that make health officials happy. "We would have hoped that in the last three or four years [smoking rates] would have dropped slightly each year. However, that has not happened," says Dick Welch, section chief for the state Health Department's Section for Nonsmoking and Health.

What's going on? This is Minnesota, after all—the state that enacted the nation's first comprehensive Clean Indoor Air Act, the first state to ban cigarette vending machines in some localities. In 1985, Minnesota was the first state to receive money from its Legislature to develop an anti-smoking media campaign. Basically, Minnesota has been a model for other states when it comes to smoke-free initiatives.

The level of tobacco control activities here is something seen in only a handful of states—states like California, Massachusetts, and New York, according to Jean Forster, Ph.D., associate professor of epidemiology at the University of Minnesota. "People in Minnesota think government regulation [of dangerous products] is more appropriate. And we're well organized." In fact, in recent years some 70 communities here have passed some kind of anti-tobacco ordinance, creating what Forster calls, "a virtual policy laboratory in Minnesota."

So, how do we explain our unimpressive statistics? Some observers suggest that the states that looked to us for leadership and copied our anti-smoking programs learned their lessons well—so well, in fact, that they've surpassed us.

Others point out that money to develop new initiatives has dried up. In 1985 the Legislature appropriated \$1.2 million for a statewide tobacco control program that included an aggressive media campaign to discourage adolescent smoking. That budget has been cut to \$60,000. "That's not enough," says Judy Knapp, Ph.D., executive director of the Minnesota Coalition for a Smoke-Free Society 2000. "When you do a media campaign it has to be up-to-date. It has to be new. We have to compete with Joe Camel. You cannot do that with \$60,000 a year."

Having said all that, it's important to put Minnesota's smoking rates in perspective. The nation as a whole isn't doing much better. Nationwide, smoking rates among adults leveled off in 1990; among youths they

haven't changed much since 1980. With progress grinding to a halt, public health officials doubt we will meet our national goal of a 15 percent smoking prevalence by the year 2000.

In other words, we're failing as a nation in our effort to go smoke-free. To explain why we can't kick the habit, a growing body of literature points to a powerful, aggressive tobacco industry that goes to great lengths to recruit new smokers to replenish the 2 million who either die or quit each year. (That industry hasn't been completely honest with the American public, according to a lawsuit filed by the Minnesota attorney general and Blue

Cross and Blue Shield of Minnesota alleging that the tobacco industry has engaged in consumer fraud and antitrust conspiracy to keep Minnesotans smoking; see article, page 23.)

"It's easy for a community to say, 'I believe smoking is wrong.' It's another to say, 'How much are you willing to spend to support that belief?' "

—RON CASE, EDEN PRAIRIE

Advertising Targets Youth

Most of the tobacco companies' new recruits are young people. Approximately 90 percent of young adults who smoke begin before the age of 20. People who don't smoke before that are unlikely ever to smoke. An estimated 3,000 children become regular smokers every day.

As Knapp's comment suggests, young recruits are lured by expensive advertising campaigns. A \$60,000 legislative appropriation is nothing compared with the \$4.6 billion the tobacco industry spent on advertising and promotion in 1991. Among other things, that money buys those Joe Camel ads, which feature a cartoon character introduced to the nation's youth by RJR Nabisco in 1988. The ad campaign has been so successful that Joe Camel is as familiar to children as Mickey Mouse, and Camel's share of the illegal children's cigarette market is \$476 million per year—a third of all cigarette sales to minors.

Youth-targeted advertising works. Three of the most heavily advertised brands, those represented by Joe Camel, Marlboro Man, and young Newport couples, account for 86 percent of illegal sales to teens (but only 35 percent of overall sales), according to a report by the Centers for Disease Control and Prevention.

Numerous studies and reports have made the connection between advertising and adolescent smoking rates. In January, *The American Journal of Public Health*

reported that increased advertising and promotional materials targeted at youths may explain why adolescent smoking rates hadn't changed much between 1974 and 1991. Two weeks later, the American Academy of Pediatrics called for a ban on tobacco and alcohol ads in all media. The AAP noted that, "In Japan, consumption of

cigarettes has increased substantially since a massive cigarette advertising campaign was begun."

But the warning had been sounded earlier, in a 1991 issue of *JAMA* devoted to tobacco use. "A total ban of tobacco advertising and promotions, as part of an effort to protect children from the dangers of tobacco, can be

Tobacco Lobby Wields More Than Money

Community initiatives may be where it's at when it comes to anti-smoking efforts, but the battle is being waged on other fronts, including the Legislature, where two bills have been introduced this session. One bill, endorsed by the Minnesota Health Care Commission, would impose a 40-cent tax increase on cigarette sales. The MMA supports the increase but in its own bill has proposed a \$2-a-pack (40 cents per year over five years) tax increase to fund the MinnesotaCare health insurance program, replacing the current 2 percent tax on health care providers. The tax also would have the effect of reducing consumption, according to studies showing that every 10 percent tax increase means a 4 percent to 6 percent drop in use, with an even greater effect on youth. The other bill, known as the "youth access bill," would put teeth into existing law (which prohibits the sale of tobacco to minors) by requiring tobacco vendors to be licensed and penalizing owners of stores that sell tobacco to minors. That bill suffered a major setback in March, when it failed on a 12-12 vote in the Commerce, Tourism and Consumer Affairs Committee. The defeat makes it unlikely that the bill will be revived.

Similar bills have been introduced in the past with little or no success, and it appears this year will be no different. The Minnesota Coalition for a Smoke-Free Society 2000 has been working to pass a youth access bill for the past four years. A watered-down version of its proposal actually made it through last session as a rider to a health and human services bill but was vetoed by the governor.

"I think there is still going to be a push to pass the bill," says attorney Ted Grindal, who has done pro-bono lobbying for the Smoke-Free Coalition the past three years. "It's too early to say what the results will be, but we're going to keep trying until we pass it."

Jean Forster, Ph.D., has few hopes for passage this year. "It would be wonderful if the state would pass a meaningful, restrictive ordinance, but chances are slim," says Forster, an associate professor in the University of Minnesota's School of Public Health. "The tobacco industry has legions of people [at the Legislature]. They have a tremendous amount of influence with the legislators."

Grindal, who spends much of his time at the Legislature trying to undo the work of the tobacco lobby, agrees. "I don't think there's any product that has more lobbyists than tobacco," he says. What's more, those lobbyists help raise funds for politicians. Grindal concedes that while there's nothing illegal or unethical about that, nevertheless, "they are extraordinarily successful in giving substantial amounts of money."

Just how much money the tobacco lobby gives is anybody's guess because the industry hides behind an array of organizations and law firms that do its bidding. "It's impossible to know how much money is spent," Forster says. "The tobacco industry hires a law firm in town. That law firm makes a donation. But you don't know where that money came from originally."

Minnesota has the third largest number of lobbyists (for all causes) in the nation, according to an article on lobbyists in the April 17, 1992, *Pioneer Press*. The article, "How the Hired Guns Work," reported a \$5,300 contribution from Philip Morris Co. to a political committee controlled by former House Speaker Robert Vanasek, DFL-New Prague, in that election year. The article also said that North State Advisors, a law firm that represents the Tobacco Institute, gave Vanasek's committee an additional \$2,200, as well as \$12,600 to the DFL House Caucus.

based on sound scientific reasoning," wrote Joseph R. DiFranza of the University of Massachusetts Medical School.

Another report in that same issue concluded: "Cigarette advertising encourages youth to smoke and should be banned."

Communities Take the Initiative, Industry Fights Back

Communities throughout Minnesota have taken such messages to heart by enacting a variety of anti-tobacco ordinances designed to counter-



Philip Morris spent more than \$183,000 in Minnesota from July 1990 to June 1991 on wining, dining, and informing lawmakers—more than any other group, the article stated. R.J. Reynolds spent \$75,000, the fourth highest in lobbyist spending.

Vanasek told reporters the contributions didn't influence him, but the article suggested that it probably wasn't coincidental that a proposed 24 cent-a-pack tax increase was held to 5 cents that year.

According to Jeanne Weigum, president of the Association for Nonsmokers-Minnesota (ANSR), lobbyists wield more than money. Many of them are influential simply because of who they are. What's more, they are conferred a measure of respectability by some of the organizations that hire them. "The men (and almost all are men) that represent the tobacco industry in Minnesota also represent other firms," Weigum says. "This buys respectability for those men and for the tobacco lobby."

Specifically, Weigum was referring to a number of lobbyists who work both sides of the fence, representing tobacco interests as well as health care organizations. The May 1994 ANSR *Bulletin* lists the names and accounts of lobbyists with seemingly conflicting agendas. According to the *Bulletin*, which obtained its information from the Minnesota Ethical Practices Board, at that time Randy Asunma lobbied for Miller-Dwan Medical Center in Duluth, as well as for Philip Morris; Andrew Kozak represented the Tobacco Institute, as well as PreferredOne and Medtronic; Robert Tennessen represented the Smokeless Council, the tobacco holding company Kohlberg Kravis and Roberts Co., and the University of Minnesota Foundation. The *Bulletin* also reported that Medica had hired Tom Kelm, who also lobbies for the Tobacco Institute. Medica, however, says it

terminated its association with North State Advisors, the firm where Kelm works, in January 1994 because of organizational changes at Medica.

Medica's president, David Strand, says that at this time neither of the organization's two lobbyists is affiliated with the tobacco industry. "Based on the growing research that attributes higher rates of illness and health care costs to smoking, Medica would avoid any relationships that could create any potential conflicts of interest, particularly with the tobacco industry," Strand says.

Weigum agrees that's how it should be. "Health organizations and legitimate businesses should not be in bed with tobacco lobbyists, because probably without even knowing it, they are giving credibility to these guys."

This year, says Weigum, the tobacco lobby probably will be able to block the cigarette tax increase. "There's a horrendous lobby against it, and a lot of people afraid of it. I think legislators are afraid to stand up and say they're for it. I think they're afraid they'll be painted as tax-and-spend liberals trying to take advantage of people who are addicted." But Weigum believes voters support such measures. "The public is way out ahead of them," she says.

The public may support stronger legislation, but it's not out there fighting for it, says Grindal. "People think it's important, but it's not a life-or-death issue. You can go to a public place, or restaurant, and there's no smoking. That's where most people come into contact with tobacco. If they don't end up being subjected to it personally, they think, 'What's the problem?' The reality is, minors are able to buy tobacco easily through retailers. That's a huge problem."

—MKF

act the impact of tobacco advertising on youth. As might be expected, the tobacco industry, which typically hides behind an array of retail organizations, fights back. A look at some of these community efforts shows that Minnesota may be down, but it's certainly not out for the count.

Two bills are pending at the Legislature (see sidebar, page 12) that could affect tobacco consumption in Minnesota, but most activity is happening at the local level. "More of the emphasis in the 1990s is being placed on communities and what can they do," says the Health Department's Welch. A decade ago, efforts focused on changing individual behavior, but in the last three to five years, a variety of grass-roots efforts have been initiated to keep a new generation from taking up a habit that is associated with more than 400,000 premature deaths annually and staggering economic costs. Typical community ordinances make it more difficult for minors to obtain cigarettes. They also try to reduce youth exposure to tobacco smoke, as well as exposure to advertising and promotion.

The community is a good place to enact anti-smok-

ing measures, according to Jean Forster, whose name is synonymous with bans on cigarette vending machines. "Some of the most creative responses come at the local level," where policymakers are closer to constituents and where the tobacco industry has less influence, she says.

Forster is currently involved in a five-year, National Cancer Institute-funded study in seven Minnesota communities to test the effects of local policy on teenage smoking rates. "It makes sense that if you make it harder for kids to buy cigarettes, the number who start smoking will be reduced," she says. "But nobody's tested that yet."

It's not easy for communities to enact smoking ordinances, however, because the tobacco industry throws its weight around, threatening legal action and organizing opposition from retailers who sell tobacco products. "[Tobacco companies] do what they can in the community to prevent actions from occurring," Welch says.

Much of the tobacco industry's work is done behind the scenes with the help of its minions—well-known law firms and local retailers. "The tobacco industry gets its allies to do its work for it in the communities and the Legislature," Forster says. Aside from independent re-



MMA Kicks Some Butts

Committed to reducing tobacco consumption among all Minnesotans and especially the state's youth, the Minnesota Medical Association has recently taken these steps to snuff out smoking:

- Supported the Minnesota Health Care Commission's recommended 40-cent tax increase on cigarettes. The association included a provision in its own proposed health system reform legislation, the Minnesota Health Care Quality and Coverage Act, calling for a \$2-per-pack (40 cents per year over five years) cigarette tax increase.
- Helped found the Tobacco Tax Coalition for a Healthy Minnesota, a broad-ranging group committed to reducing tobacco consumption among all Minnesotans, especially children and youth, and to using tobacco tax revenue to fund health initiatives in the state.
- Voted at its 1994 Annual Meeting to support the lawsuit brought by the state and Blue Cross and Blue Shield alleging that tobacco companies violated state consumer protection and antitrust laws.
- Taught students from the Moorhead, Stillwater, and Rosemount school districts how to reach policymakers and the media with their concerns about tobacco use by young people. MMA staff members Mark Vukelich and Molly Sigel this winter taught students how to contact their city council members and legislators, how to lobby and testify in favor of ordinances to restrict youth access to tobacco, and how to share their views with the media through news releases, letters to the editor, and public service announcements. The training was coordinated by ASSIST, a collaboration of the Minnesota Department of Health and the American Cancer Society, Minnesota Division.
- Participated in the February 27 Kick Butts rally, which brought students from throughout Minnesota to the state Capitol to talk to legislators about concerns over youths' easy access to tobacco.

tailers, the industry works with groups that receive tobacco money, such as the Minnesota Coalition for Responsible Vending Sales, the Minnesota Coalition for Responsible Retailers, and the Association for Responsible Merchandising.

One of those allies, according to Forster, is lobbyist Tom Briant, who works on behalf of tobacco interests. By all accounts, Briant (whose name recurred in interviews for this story and who declined to be interviewed) gets around. He was a member of an Eden Prairie task force that was established to reconsider (in the face of retail opposition) an ordinance aimed at keeping tobacco out of the hands of minors. "He's gotten around to a lot of little communities in Minnesota," Forster says, including at least two of the seven towns in her study. "Where there was little opposition before, he organizes opposition among the merchants."

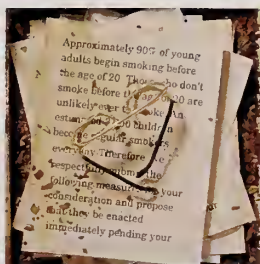
The retail opposition argues that tobacco ordinances threaten their economic livelihood and trample their individual rights. Yet those who craft anti-smoking laws insist their intention is merely to keep tobacco out of the hands of minors. "We're not about prohibition or keeping addicted adult smokers from getting tobacco," Forster says. "The kinds of things we do don't really inconvenience adult smokers."

Eden Prairie passes compromise ordinance

That's not how retailers saw it when they challenged the Eden Prairie City Council to reconsider an ordinance enacted last July to limit juvenile access to tobacco. The ordinance wasn't intended to infringe on individual rights, says Ron Case, the council member who chaired the tobacco ordinance task force. "We're not talking about that. We're talking about limiting access to kids."

Challenged by the retailers, the council last January passed a compromise ordinance requiring that cigarettes be kept behind the counter but making it easier for clerks to retrieve them. The council stood firm on several other conditions, including one that prohibits minors from selling tobacco products.

Case is proud of Eden Prairie's initiative and hopes it will have a ripple effect. "I think cities need to become more proactive in protecting their own borders and begin to set precedents," he says. "Each community tends to look at the others for a comfort level. Maybe this [ordinance] will give them some strength in the future not to back away. We can say, 'It has worked.'"



Other communities back down

But some towns are more gun-shy than Eden Prairie and are easily put off by the threat of protracted fights and legal battles with merchant groups. In Burnsville, for example, a measure to license tobacco vendors failed in the wake of intense business lobbying, according to City Council Member Glenn McKee. The town had planned to use license fees to pay for compliance checks after a survey showed that most local businesses were selling tobacco to minors. McKee believes the votes were there until the lobbying campaign began.

In Brooklyn Center, the City Council indefinitely tabled an ordinance that would have restricted tobacco advertising and promotions seen by children, after residents complained about the costs of defending the ordinance in court.

Preston goes head-to-head with industry

The threat of a lawsuit didn't discourage the Preston, Minnesota, City Council, however. Last June, it passed the same restrictive ordinance that Brooklyn Center had shelved in 1992.

Initially, nobody paid much attention when Preston's City Council passed the ordinance severely restricting tobacco advertising in retail stores. In fact, only a handful of newspapers ran an account of the town's tough stance, even after press packets were mailed out across the country hailing Preston as the first city in the nation to all but ban tobacco ads in stores. Even the tobacco industry, known for aggressively fighting such restrictive measures, ignored the tiny town.

One might have expected more reaction to a law that prohibits the display of tobacco ads with appealing logos, pictures, or cartoon characters. Anything bearing the brand name logo that tobacco companies traditionally use to promote their product—special bins, clocks, banners, garbage cans—was banned in Preston. (Tobacco companies pay retailers \$1.5 billion a year for such displays.) But a town in southeastern Minnesota with only eight tobacco vendors and 1,530 people isn't likely to grab the spotlight, even when it beats everyone else to the punch.

Since December 5, however, all eyes have been on Preston. That's when the tobacco industry struck back, filing a suit in the U.S. District Court claiming the town had violated the First Amendment and civil rights of Binh Chiglo, the owner of Citgo One Stop, a filling station with about \$90,000 in annual tobacco sales.

Had Preston been an isolated case, the tobacco industry might have ignored it, but too many other communities were starting to take on the industry with some success. At least that's how Jeanne Weigum explains the sudden legal challenge. Weigum, president of the Association for Nonsmokers-Minnesota, a group that was instrumental in creating Minnesota's Clean Indoor Air Act in 1975 and that helped Preston craft its ordinance, says that since similar events were taking place in other communities, the tobacco industry had nothing to lose by taking Preston to court.

First, a Baltimore ordinance restricting tobacco and alcohol billboard ads survived a legal challenge (it is now being appealed), Weigum says. Then, two small communities in Massachusetts passed advertising bans similar to Preston's. There was also an unfavorable ruling in California relating to Joe Camel ads. "If Baltimore hadn't happened, and the two little communities in Massachusetts and California, then Preston wouldn't have been sued," Weigum surmises.

Preston plans to remain tough, in part because of the overwhelming support it has received. But, as might be expected, not everyone stands behind the ordinance. State Rep. Greg Davids, IR, calls the ordinance a frivolous action and argues that the town has better things to do. "I told the City Council members, 'I don't want this to cost the city one dime,'" says Davids, a former council member and three-term mayor.

In this case, the Minnesota League of Cities is providing free legal representation, but legal costs are a legitimate concern. "I don't know that any community is willing to spend massive amounts of tax dollars when you have the tobacco industry coming in with a lot of money," says Eden Prairie's Case. "It's easy for a community to say, 'I believe smoking is wrong.' It's another to say, 'How much are you willing to spend to support that belief?'"

Costs aside, Davids' other concern is that Preston is a pawn, unnecessarily caught up in a struggle between two much bigger forces. "It's two special interest groups going at each other, and they needed some guinea pig, and Preston bought into it," he says. "I get into a lot of fights. I don't think this is one to pick."

Preston may be caught in the crossfire, but few would agree that the fight isn't worth picking. If the tobacco industry wins, it will go on intimidating municipalities nationwide with the threat of expensive lawsuits. If it loses, those same communities will have a legal leg to stand on. In other words, the Preston case could send Joe Camel packing.

"To my knowledge, it's the first case that deals with

point-of-sale advertising. It's certainly brand new in Minnesota," says Jon Iverson, the attorney representing Preston. Iverson explains that the ordinance is based on the U.S. Surgeon General's report of 1994, which states that the earlier young people begin using tobacco products, the more likely they are to continue using them as adults, and that most persons under age 18 who use tobacco products are addicted to nicotine. By restricting tobacco advertising at the point of sale, the ordinance is intended to cut down on the sale of tobacco to minors.

"These are aggressive ordinances that we are seeking to find new means to prevent minors from smoking," Iverson explains. "There's ample precedent in case law to say that promotion creates usage." But, he adds, there's no precedent for the advertising ban. "That's one of the reasons why R.J. Reynolds is so interested in it." (The tobacco company is paying the plaintiff's legal fees.)

If Preston prevails, other communities will likely follow suit. A favorable ruling for Preston might be all the encouragement Brooklyn Center needs to pass the advertising ban it once tabled. And it might be all Ashland, Wisconsin, needs to pass a law of its own. Fear of a lawsuit kept Ashland from taking similar action, the town's administrator told the *Pioneer Press* in December.

Even Eden Prairie, which already has a tough ordinance, is watching Preston, as well as the Baltimore billboard case now pending in the U.S. Court of Appeals. Depending on the outcome, Council Member Case says he hopes Eden Prairie becomes the first city in Minnesota to combine a billboard ban with a point-of-purchase ban. "I would like to see us pursue proactive measures to continue to limit the publicity access to juveniles." Case believes that 95 percent of the town's 19,000, mostly middle-class families would support the fight. "Anything we could do as a city that would promote health consciousness and basically limit juvenile access to dangerous products, I think would be received well."

Juveniles. Marketing researchers call them "consumers in training." The battle is over them—the next generation of smokers. "I think we're fighting over the same people. It's the kids," says Jeanne Weigum. "The industry wants them as lifetime customers. We want them too, to save their lives. Kids are the target. The industry would not agree with that. But without the kids, they're a dying industry." MM

Miriam Feldman is a free-lance writer in Minneapolis and a frequent contributor to *Minnesota Medicine*.



I would like to learn more about how WEBB FINANCIAL GROUP
can help me achieve my investment and income objectives.

Name _____

Address _____

City _____

State _____

Phone _____

Zip _____

Please contact me at my ☐ Home ☐ Office

☐ Please send me information on your products and services.

I currently invest in

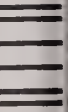
☐ Stocks

☐ Bonds

☐ Mutual Funds

☐ CDs

☐ Annuities



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

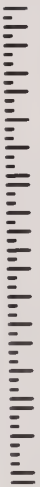
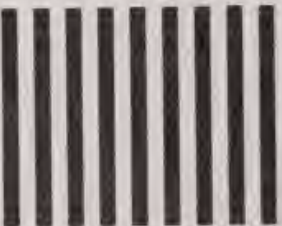
FIRST-CLASS MAIL PERMIT NO. 25248 MPLS MN

POSTAGE WILL BE PAID BY ADDRESSEE

WEBB FINANCIAL GROUP

6600 France Av S, Ste 370

Edina, MN 55435-9886



WEBB FINANCIAL GROUP

INVESTMENT ADVISORS



LeAnn

Les

Jerry

Webb Financial Group has over **44** years in combined investment experience.

We are recognized as a leader in **managing** low to moderate risk
NO-LOAD FUND portfolios for individuals and retirement plans.

We primarily work with portfolios of \$200,000 or more.

Our mission is to help our clients achieve their investment and income objectives,
while maintaining a long term safe haven for their assets.

Call a personal investment advisor at
Webb Financial Group for a no-cost, no-obligation consultation.

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

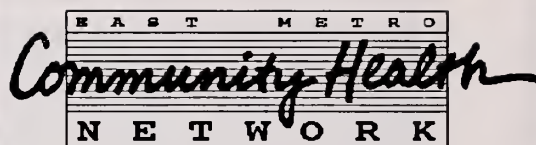
At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



**Central Minnesota
Group Health Plan**

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE



Physician Family Medicine

The East Metro Community Health Network is seeking a BC/BE family medicine physician with an interest in community-based health care. The ideal candidate will have an interest in working with low-income/minority populations. Must be licensed to practice in Minnesota. Attractive hours, salary, benefits. No call. Full and part-time positions available. Interested applicants send CVs to:

East Metro Community Health Network
2550 University Avenue West, Suite 460S
St. Paul, MN 55114
TEL: (612) 489-2273
EOE

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 260 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice for the Region
- Orthopaedics - Detroit Lakes, Bemidji
- General Surgery - Wahpeton
- Psychiatry ■ OB/GYN
- Urgent Care ■ ENT
- Rheumatology ■ Pediatrics - Bemidji
- Internal Medicine - Detroit Lakes



For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010



MeritCare Medical Group
737 Broadway • Fargo, ND 58123



The Economic and Human Costs of Smoking in Minnesota

One in six Minnesotans die a smoking-related death, leading to economic costs of more than \$1 billion annually—losses that can be prevented in part through public policy initiatives.

Dick Welch, Ed.S., Kathy Daly, Ph.D., and Judith Hilton

Editor's Note: Smoking is deadly. While that comes as no surprise, the fact is, we physicians often fail to give this risky habit the emphasis it deserves. Smoking intervention may be frustrating for physicians because little is as easy as writing a prescription. But how many useful prescriptions can you write for the person with terminal emphysema or cardiovascular disease? A few months ago, our Public Health Report talked about stopping smoking in children and young adults. This month, we present an assessment of the outcomes when those smoking cessation attempts are not successful. The outcomes do not look good. Although physicians cannot do everything necessary to stop Americans from smoking, we are an important part of the puzzle in successful smoking cessation.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

More than 400,000 deaths (approximately 19% of total deaths) in the United States were attributable to tobacco in 1990,¹ and in 1989, the U.S. surgeon general identified cigarette smoking as the chief preventable cause of premature mortality and excess morbidity in our society.²

The Minnesota Department of Health recently estimated the economic and health costs of cigarette smoking for Minnesotans using 1992 data for comparison with earlier estimates based on 1990 data. The data show that the economic costs associated with smoking have increased while the health burden has remained comparatively flat, as have smoking rates (approximately 22%) for adults over the past three years. The study is updated periodically to provide data that public health officials, medical professionals, and other policymakers may use for a variety of purposes, such as to:

- estimate the impact of smoking on disease;
- develop policy and plans for local and state tobacco use prevention and control;
- develop economic recommendations for tobacco use prevention and control programs.

The Health Department used 1992 Minnesota mortality and smoking data and software distributed by the Office on Smoking and Health of the Centers for Disease Control and Prevention³ to estimate the health and economic costs of smoking in

Minnesota. The software program calculates smoking-attributable fractions for causes of death using relative risk estimates and smoking prevalence rates. These fractions represent the portion of deaths and health care costs that are the result of smoking, e.g., 79% of lung cancer and 18% of ischemic heart disease are due to smoking. These smoking-attributable fractions are then multiplied by the number of deaths in Minnesota for each cause and by health care expenditures in the state to produce estimates of the smoking-attributable mortality, morbidity, and economic costs for Minnesota.

The health care expenditure data are from the Health Care Financing Administration, and smoking prevalence data for Minnesota are from the 1992 Behavioral Risk Factor Surveillance System, a telephone survey of adults. Direct and indirect cost estimates were calculated for Minnesota. Direct health care costs include dollars spent on hospitalization, physicians, other health care professionals, nursing home care, and medications. Indirect costs of smoking are the value of future earnings and lost productivity from smoking-related illness and premature deaths. The economic and health costs of secondhand smoke (environmental tobacco smoke) are not included in the calculations. The Environmental Protection Agency in 1992 classified secondhand smoke as a Group A carcinogen.⁴ Had secondhand smoke data been available for inclusion in

Table 1

Smoking-attributable causes of death, Minnesota, 1992

Cause of death	ICD-9 code	Total deaths per code	Smoking-attributable fraction	Smoking-attributable deaths
Cancer deaths*				
Lip, oral cavity	140-149	116	72%	84
Esophagus	150	157	71%	111
Pancreas	157	467	21%	97
Larynx	161	39	79%	31
Lung	162	2,009	79%	1,592
Uterine cervix	180	44	25%	11
Bladder	188	192	38%	72
Kidney	189	240	29%	69
Cardiovascular deaths*				
Rheumatic heart disease	390-398	78	13%	10
Hypertension	401-404	463	13%	62
Ischemic heart disease	410-414	7,032	18%	1,296
Pulmonary heart disease	415-416	169	14%	24
Other heart disease	420-429	2,720	14%	391
Cerebrovascular	430-438	2,806	13%	352
Atherosclerosis	440	347	32%	111
Other arterial disease	441-448	534	37%	198
Lung disease deaths*				
Respiratory TB	010-012	6	17%	1
Pneumonia/influenza	480-487	1,391	21%	291
Bronchitis/emphysema	490-491, 492	273	78%	205
Asthma	493	85	20%	17
Chronic airways obstruction	496	1,122	78%	874
Perinatal conditions†				
Low birthweight	765	31	13%	4
Respiratory distress syndrome	769	14	14%	2
Respiratory condition newborn	770	33	15%	5
SIDS	798	89	10%	9
Other conditions‡				
Burn deaths	E890-E899	44	39%	17

*Ages 35+; †Ages 0-1; ‡All ages

the calculations for the study, costs would likely have been much higher.

Table 1 shows the smoking-attributable mortality for Minnesota for 1992 by cause of death, and Table 2 summarizes these data for major causes. In 1992 in Minnesota, 5,900 deaths (17% of all deaths) were estimated to be attributable to smoking. Estimated economic costs attributable to smoking totaled more than \$1.1 billion in 1992 (compared with \$996 million in 1990), which includes nearly \$470 million for direct health care costs and more than \$678 million for lost income as a result of premature death or disability (see Figure 1). This results in a 1992 annual cost of \$262 for each Minnesota resident (compared with \$228 in 1990).

Health Burden Is Large

Smoking-related diseases accounted for more than 5,900 deaths in 1992 and represent the leading cause of preventable mortality. This trend can be expected to continue while smoking rates remain near 22%. Smoking accounts for approximately one of every six deaths, or the equivalent of 16 people dying every day in Minnesota from smoking-attributable illness. Translating a comparison used by Wisconsin researchers, more people die every year from smoking than live in a community the size of Cambridge, Chisholm, Forest Lake, or Litchfield.⁵

Children and Communities Hold Solutions

One solution is to protect our children from tobacco access and availability, tobacco advertising, and exposure to environmental tobacco smoke. According to a 1994 Institute of Medicine report, 71% of smokers begin daily smoking during adolescence, and nicotine addiction begins during the first few years of tobacco use.⁶ Solving this public health problem requires action by each community and county of Minnesota (see related story, page 10).

In addition to influencing their young patients, physicians can lead community efforts to protect children and youth from access to tobacco.

co products and exposure to tobacco smoke and tobacco advertising. In the article, "Youth Addiction to Tobacco," in the December 1994 *Minnesota Medicine* (page 28), Kottke et al. describe the contributions physicians can make through community action.⁷

The Minnesota Health Care Commission, regional coordinating boards, local public health agencies, and medical practitioners are seeking ways to improve the health of Minnesotans and at the same time to contain or reduce health care costs. They are often selecting public policy goals directed toward reducing tobacco use. The data from the study reported here along with the positive examples set by several Minnesota communities that have adopted community ordinances limiting youth access to tobacco and advertising—Eden Prairie, Preston, Roseville, and White Bear Lake—provide helpful guidance in reducing young people's access to tobacco and exposure to tobacco smoke and tobacco advertising. Taking action throughout the state should help lower smoking rates and, subsequently, reduce the health care costs of tobacco use.

Costs Are Greater than Revenue Raised

Some people think the economic and health care costs resulting from smoking are offset by the revenue generated from the state tobacco excise tax. The revenue data from 1992 do not support that claim. In fiscal year 1992, excise tax revenue on cigarettes totaled \$156.6 million, or 43 cents per pack sold. This revenue is dwarfed by the total estimated cost of smoking (disability and health care costs) borne by all Minnesota residents—\$1.1 billion—which is more than seven times greater than the tax revenue raised.

Conclusion

Given the economic and human burden of smoking, it is unacceptable to continue the state's current 22 percent smoking rate. Minnesota public health has a primary goal to lower

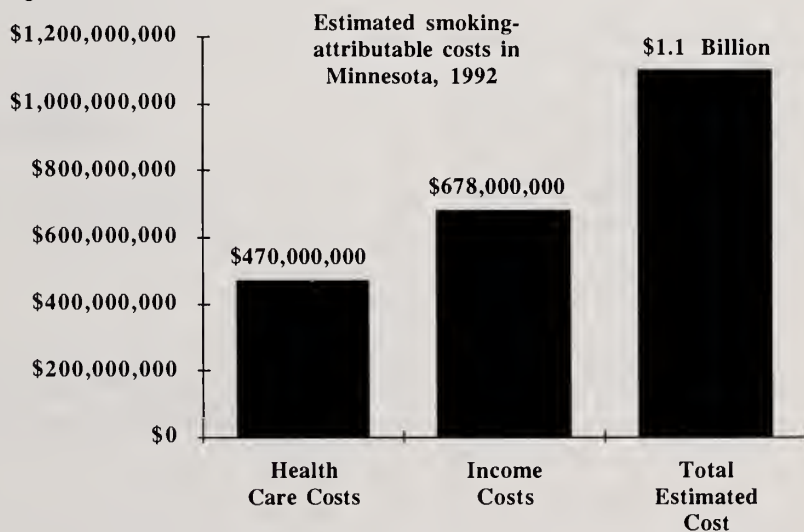
Table 2

Summary of smoking-attributable causes of death, Minnesota, 1992

Cause of death	ICD-9 code	Total deaths	Smoking-attributable deaths	Percent due to smoking
Cancer	140-239	8,653	2,067	24%
Cardiovascular disease	390-459	14,215	2,444	17%
Lung disease	460-519, 010-018	3,296	1,388	42%
Perinatal conditions	760-779*	186	20	11%
Other conditions	**	8,625	17	<1%
All causes		34,978	5,936	17%

*Includes all deaths under 1 year of age; **Includes all other causes of death

Figure 1



the smoking rate to 15 percent by the year 2000. Physicians can help in two important ways: 1) by consistently encouraging young and adult patients not to smoke, and 2) by actively supporting communities' policy initiatives that protect children from access to tobacco, from exposure to environmental tobacco smoke, and from exposure to tobacco advertising and promotion targeted toward youth. Working together at the community level is essential to accomplishing this goal. **MM**

Dick Welch is chief of the Section for Nonsmoking and Health, Division

of Family Health, at the Minnesota Department of Health. Kathy Daly is an assistant professor in the Department of Otolaryngology at the University of Minnesota. Judith Hilton is a health educator in the Section for Nonsmoking and Health at the Minnesota Department of Health.

REFERENCES

1. McGinnis JM, Foege WH. Actual causes of death in the United States. *JAMA* 1993; 270:2207-12.
2. U.S. Department of Health and Human Services. Reducing the health consequences of smoking: 25 years of progress: report of the surgeon general. Rockville, Maryland:

U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1989. DHHS publication no. (CDC); 89-8411.

3. Schultz JM, Novotny TE, Rice DP. SAMMEC 2.1. Smoking-attributable mortality, morbidity, and economic costs: computer software and documentation. Atlanta: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1992 September.

4. U.S. Environmental Protection Agency. Respiratory health effects of passive smoking: lung cancer and other disorders. Washington, D.C.: Office of Research and Development and Office of Air and Radiation, 1992 December. EPA/600/6-90/006F.

5. Moss ME, Remington PL, Peterson DE. The costs of smoking in Wisconsin: a silent epidemic. *Wis Med J* 1990;89:646-8.

6. Lynch BS, Bonnie RJ, eds. Growing up tobacco free: preventing nicotine addiction in children and youth. Washington, D.C.: National Academy Press, 1994.

7. Kortke TE, Mantak FJ, Solberg LI. Youth addiction to tobacco. *Minn Med* 1994; 77(12):28-31.



Family Practice

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 155 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

North Central Medical Conference

Presents Two Exciting Tours From Minneapolis/St. Paul



SWITZERLAND & GERMANY

September 8-16, 1995
\$995.00

Per person, double occupancy.
(Plus \$34.00 taxes.)

We invite you to experience the splendor of the Swiss Alps and a chance to sample the famous "Black Forest Gateau!"



IRELAND

September 29-October 7, 1995
\$995.00

Per person, double occupancy.
(Plus \$37.00 taxes.)

Welcome to Ireland. Visit Galway, Blarney, Dublin, and other interesting cities and towns. A hundred thousand welcomes await you!

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.

For additional information and a color brochure contact:

GLOBAL HOLIDAYS

9725 Garfield Avenue South, Minneapolis, MN 55420-4240
(612) 948-8322 Toll Free: 1-800-842-9023

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.
Employee Benefits Attorneys
2600 Eagan Woods Drive, #450
Eagan, MN 55121-1152

Practice limited to ERISA since 1988
Tel: 612-452-9322
Fax: 612-452-9355

Industry Under Fire: Minnesota v. The Tobacco Industry

Seeking to recover millions of dollars spent on tobacco-related health care costs annually, the state is suing the tobacco industry for consumer fraud and antitrust conspiracy.

Hubert H. Humphrey III

Sixteen-year-old Alexis Hendricks was nervous the first time she tried to buy cigarettes. A nonsmoker who doesn't look as old as she is, Alexis had volunteered to assist a "secret shopper" project that monitors compliance with laws that ban tobacco sales to minors. Alexis assumed she would be thrown out of the local restaurant on her ear when she inquired about buying a pack of cigarettes. But she recalls in wonderment how, not one, not two, but four separate restaurant employees helped steer her toward a cigarette machine that dispensed a deadly, addictive product to the Lakeville student.

Every day, 3,000 more kids like Alexis start smoking. These adolescent smokers are more likely to remain smokers for the rest of their lives, and they are more likely to smoke heavily. One-quarter of these kids will die of tobacco-related illness.

This is why the Minnesota Attorney General's Office and Blue Cross and Blue Shield of Minnesota have decided to take action against the tobacco industry for violating Minnesota's consumer fraud and antitrust laws. Kids are as familiar with Joe Camel as with Mickey Mouse, and nine of 10 smokers start before age 21. Cigarette addiction kills more people than alcohol, homicide, AIDS, cocaine, heroin, and motor vehicles combined.

What is Minnesota seeking? As the largest purchaser of health care in the state, Minnesota wants to recov-

er damages. Taxpayers pay more than \$350 million each year in tobacco-related health care costs, and the suit seeks to recover the portion paid by the state and by co-plaintiff BCBSM to treat tobacco-related illnesses. In addition to money, the suit calls for change. It asks that the tobacco industry's 40-year conspiracy be brought to an end and that the tobacco companies be forced to disclose research they have been covering up for years. It also would require tobacco companies to fund clinical smoking-cessation programs to help remedy the harm they have caused.

We are not the only groups waging battle against the tobacco industry. During the past year, the battle has proceeded on two fronts: 1) in government organizations, and 2) in court, as with our suit and many others filed in recent months.

The First Front: FDA and Congress Fight Back

Americans saw the first new front open on the evening news, as the Food and Drug Administration revealed "mounting evidence" that cigarette makers add nicotine to their products to create and satisfy an addiction to cigarettes, as asserted by FDA Chief David Kessler, M.D., in a February 1994 letter to the Coalition on Smoking OR Health. Kessler further stated that, if proven, such conduct would give the FDA "a legal basis to regulate these products" as drugs.

Kessler's disclosures prompted congressional hearings in the House of Representatives Subcommittee on Health and Environment. Committee Chair Rep. Henry Waxman, D-California, compared the impact of tobacco smoking with "two fully loaded jumbo jets crashing each day, killing all aboard" and declared that his hearings marked "the beginning of a new relationship between Congress and the tobacco companies."

News of the Waxman hearings soon focused on the chief executive officers of the companies under fire. One by one, on April 14, 1994, the tobacco bosses told subcommittee members and a national television audience that they do not believe cigarettes are addictive. Editorialists from coast to coast greeted this testimony with derision, a reaction that intensified when, weeks later, the Waxman Committee released internal industry documents showing that the tobacco companies have known about nicotine's addictiveness from decades of their own research.

The Second Front Opens in Court

The second front in the battle against smoking opened in court, with the onrush of what Northeastern University Professor Richard Daynard called "the third wave of tobacco products liability cases." This third wave differs significantly from the first two waves, which unsuccessfully focused on traditional personal

liability suits. With such suits, the tobacco cartel's lawyers have found it relatively easy to show that the individual involved understood the risks of smoking or to muddy the waters about causation of the affliction. For instance, it is difficult for a victim to prove with certainty that a respiratory illness was caused by smoking, as opposed to air pollution or some other environmental factor. The tobacco industry has proven very adept at defending against such lawsuits.

Tobacco foes across the country, bolstered by ever-increasing scientific data and inside information about the industry, have begun to score significant success with new theories of liability: A Florida court certified as legitimate a plaintiff class of flight attendants involuntarily exposed to environmental tobacco smoke, and Mississippi Attorney General Mike Moore has filed a products liability suit to recover the money his state has spent to cover the tobacco-related medical expenses of indigent citizens. By naming itself as the injured party, Mississippi hopes to preclude the defense strategy of blaming plaintiffs' "contributory negligence" (choosing to smoke) as a cause of illness. These two lawsuits, and others under way in California and Louisiana (see table, page 25) seem likely to avoid the pitfalls of the two earlier waves of lawsuits. In addition, the new lawsuits are well-financed, often by large law firms.

Minnesota's Case

Minnesota's case takes yet another approach. While Mississippi's suit is closer to a traditional personal liability action, Minnesota is the first to take on the tobacco industry for violating consumer fraud and antitrust laws. Minnesota's consumer fraud laws say companies cannot knowingly lie about their products, and the antitrust laws say companies cannot conspire with competitors to manipulate the free market to their advantage. Recently disclosed evidence indicates what many have long suspected—the tobacco industry has been violating these laws for decades. West Virginia has since filed an action similar to Minnesota's, and many

other states are considering following our lead.

The Minnesota lawsuit, which the Attorney General's Office filed with Blue Cross and Blue Shield of Minnesota against six domestic cigarette manufacturers, two industry trade associations, and a foreign parent company, brings together an unprecedented combination of resource-

“Recently disclosed
evidence indicates
what many have long
suspected—the
tobacco industry has
been violating
consumer fraud and
antitrust laws for
decades.”

es from the public and private sectors: the law enforcement expertise and legal powers of the Attorney General's Office, the health care savvy of BCBSM, and the hard-driving litigation talents of Robins, Kaplan, Miller & Ciresi—a firm that has won huge cases, such as the Bhopal, India, chemical disaster and the Dalkon Shield case. This may be the most formidable legal team the tobacco industry has faced.

Minnesota's powerful consumer protection and antitrust statutes, and the five alleged violations that form the core of the complaint, place the focus of this suit squarely on the commercial conduct of the cigarette manufacturers—not on the conduct of individual smokers. Liability will depend on whether the tobacco companies have made misrepresentations to the public and combined to manipulate their markets, not on whether injured smokers contributed to their own problems by “choosing” to smoke.

What evidence supports the allegations of consumer fraud and re-

straints of trade? Consider a small sample of facts that have recently come to light about what the cigarette industry knew, and when they knew it.

The Evidence

In 1953, after publication of the first studies warning of the health effects of cigarette smoking, the six cigarette companies published advertisements across the country, including Minnesota, promising to tell their customers the full truth about smoking and health as that truth became known. The industry conducted and sponsored significant research about the health effects of its products, and we now know that the industry discovered tobacco is deadly and addictive. For example, in 1963 the general counsel of Brown & Williamson, a cigarette manufacturer, wrote an internal memo that admitted, “we are, then, in the business of selling nicotine, an addictive drug.” It further acknowledged that cigarettes “cause, or predispose, lung cancer ... contribute to certain cardiovascular disorders ... [and] may well be truly causative in emphysema, etc.” A 1972 memo said, “The cigarette should not be conceived as a product, but as a package. The product is nicotine.” These were internal communications; to this day, the tobacco industry continues to publicly deny that tobacco is addictive or deadly.

As for antitrust allegations, internal memos show that cigarette companies have long conspired to manipulate the marketplace. They reached a “gentleman's agreement” to suppress independent research that might undercut their public positions on smoking and health. In late 1953, tobacco company executives met at the Plaza Hotel in New York and concocted a public relations scheme to hide the truth about the hazards of smoking. In a subsequent memo, they acknowledge that “For nearly 20 years, this industry has employed a single strategy to defend itself on three major fronts—litigation, politics, and public opinion. ... [The strategy] has always been a holding strategy, consisting of ... creating doubt about the health charge without actually denying it.”



Table 1

THE MOUNTING LEGAL BATTLE AGAINST TOBACCO

Ten lawsuits have been filed against cigarette makers since March 1994 in the United States.

When	By whom	Against	Where filed	How much	Issue
March 29	Class action led by 26 law firms	Philip Morris, R.J. Reynolds, four other cigarette makers	Federal court in Louisiana	Not stated	Whether tobacco companies manipulated nicotine levels in cigarettes to addict smokers.
March 30	Class action for all users of the nicotine patch, led by a New York law firm	Philip Morris, other major tobacco companies	Federal court in San Diego	\$9 billion	Whether tobacco companies issued false information about the addictiveness of nicotine.
April 4	Stockholder	Philip Morris	Federal court in Manhattan	Not stated	Revolves around not telling the truth about nicotine addiction.
April 28	Karen Sparks, Seattle mother of two	R.J. Reynolds	Washington State Superior Court	Not stated	Whether R.J. Reynolds directed its Joe Camel advertising toward children.
May 5	Class action by smokers, led by a Miami lawyer	13 cigarette makers and industry organizations	Dade County (Fla.) Circuit Court	Not stated	Whether tobacco companies defrauded consumers.
May 14	Estate of Burl Butler	Six tobacco companies	Jones County (Miss.) Circuit Court	\$650 million	Whether nonsmoker Butler's death can be blamed on secondhand smoke in his barbershop.
May 23	Mississippi attorney general	13 tobacco companies	Jackson County (Miss.) Chancery Court	\$500 billion	Whether the tobacco industry should pay \$500 billion in health care costs for tobacco-related illnesses.
Aug. 17	Minnesota attorney general, BCBSM	Seven tobacco companies and two industry organizations	Ramsey County (Minn.) District Court	Not stated	Whether industry misrepresented and colluded on research and should pay for increased costs.
Sept. 20	West Virginia attorney general	17 tobacco cos., a cigarette components mnfr., industry, trade associations, consultants, tobacco wholesalers	Kanawha County (W. Va.) Circuit Court	Not stated	Seeking reimbursement for providing medical care to citizens sick with tobacco-related illnesses and to halt the promotion of cigarettes to minors.
Feb. 20	Fla. attorney general on behalf of Medicaid	21 cigarette makers, including consulting PR firms	Palm Beach County (Fla.) Circuit Court	\$1.43 billion	To recover millions of taxpayer dollars in Medicaid payments for health problems attributed to tobacco-related illnesses and to halt selling practices.

And when the subject of safer cigarettes came up, they acted together to keep them off the market, fearing that marketing a "safer" cigarette would amount to a confession that the industry's mainstay prod-

ucts were *not* safe. A researcher from Liggett, the company that produced a "safer" cigarette, admitted that the company's management "felt that such a cigarette, if put on the market, would seriously indict them for hav-

ing sold other types of cigarettes that didn't contain this." He went on to say that the president of Liggett "made the statement that he was told by someone in the Philip Morris company that if we tried to market such

a product ... they would clobber us."

Obviously, the American people have not seen the full disclosure the industry promised in its advertising. Instead, the defendants suppressed adverse research results, and another generation of Americans reached for their cigarettes without knowing what they were really lighting up. Last spring millions witnessed the perpetuation of the industry's party line during the Waxman hearings. Using false advertisements to sell products is classic consumer fraud, while agreeing not to compete in new product markets is a violation of antitrust law made all the more obvious by the defendants' manifest monopoly power.

The Tobacco Industry's Counteroffensive

The merit of Minnesota's case may seem obvious, but this fight is far from over. The cigarette industry continues to tout its string of successes in the first two waves of liability litigation, while bracing to meet the third. Tobacco companies will fight with every weapon they have.

The action in court has thus far been limited. Minnesota has filed its complaint, and the tobacco industry has filed its answers, predictably denying Minnesota's allegations. The defendants also moved for dismissal of the law firm Robins, Kaplan, Miller & Ciresi, claiming conflict of interest. That attempt was quickly thrown out by the judge. If history is any indication, the tobacco industry will attempt many more procedural maneuvers like this. They'll try every motion and delaying tactic in the book to wear down the plaintiffs. But unlike the tobacco cartel's other opponents, Minnesota has the expertise and resources to go head-to-head with them.

Out of court, the tobacco industry will likely fight back with a blizzard of tobacco industry propaganda, the likes of which have never appeared in Minnesota. It may claim the lawsuit will bankrupt state government, even though outside counsel has agreed to absorb the costs. It may say cigarettes are being singled out, although cigarettes are unlike alcohol and other products in that

they are the only consumer product that causes death when used as intended by the manufacturer. They may say the case is about smokers assuming personal responsibility for the risks they've taken, even though the industry's behavior is the subject of the lawsuit, not smokers' behavior. They may say the amount they pay in taxes more than makes up for any harm they may have caused, although paying taxes doesn't give them the license to engage in conspiracies to defraud the public. They may say the lawsuit is antibusiness, although the case is a statement of support for all the honest businesses who obey the law and are unfairly saddled with the tobacco-related costs of health care.

The Battle Continues

So far, the new year has brought promising news from courtrooms around the country, but reverses on the federal front. The Mississippi attorney general has so far won his procedural battles and is poised to plunge into the substance of his case. Meanwhile, in late February, within days of Mississippi's procedural victory, Florida became the fourth state to file against the tobacco industry. A critical component of the Florida case will be a 1994 state law removing the industry's common law comparative fault defense. That same eventful week saw a third critical development when the Federal District Court for the Eastern District of Louisiana certified a class action that may number 50 million Americans—"all nicotine-dependent persons in the United States" and their heirs and estates.

The recent elections, however, yielded less ground for optimism: they elevated one of the tobacco industry's most faithful advocates, Rep. Thomas Bliley (R-North Carolina) to chair of the House Commerce Committee. The impending change in congressional attitudes toward smoking is a reminder not to be overconfident.

Conclusion

A just cause is the best foundation for any undertaking such as this lawsuit. Our best chance of success comes

with the support and efforts of groups such as the Minnesota Medical Association, which passed a resolution at its last Annual Meeting to support the lawsuit.

The attorney general's office is often asked why it stuck its neck out to take on one of the nation's most powerful interest groups. The answer is simple. Left unchecked, the tobacco industry will continue to use Joe Camel and other marketing ploys to hook another generation of kids like Alexis Hendricks on deadly products. Minnesota's landmark tobacco lawsuit is about saving Alexis' generation and subsequent generations from the lethal effects and the costs smoking inflicts on society. **MM**

Hubert H. Humphrey III is Minnesota attorney general.

MINNESOTA LICENSED LOCUM TENENS PHYSICIANS AVAILABLE!

For hassle-free help to cover for vacations or absences from your practice, call today. All major specialties covered.

Medical review officers now on staff.



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.

Eight First Ave. S.
Buffalo, MN 55313

Phone: 800/876-7171

COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
 Bloomington, MN 55437
 Local (612) 881-0618
 WATS (800) 328-6246
 FAX (612) 881-7297



C. F.
anderson
 COMPANY, INC.

Just for a Moment Imagine...

...what you want life and practice to be.



Aberdeen is a major regional medical center, with a modern 225-bed hospital and over 70 practicing physicians. Serving northeast South Dakota and southeast North Dakota. A community with concern for your needs and respect for your privacy.

Opportunities available:

- Family Practice • Orthopedic Surgery
- Pediatrics • Urology
- Nephrology

**Aberdeen... Life & Practice, Just
 As You Imagined.**

St. Luke's Midland
 Regional Medical Center



Contact: Bebe Janish

305 S. State Street • Aberdeen, S.D. 57401

605-622-5874

PRIMARY CARE PHYSICIANS

Heartland Primary Care is seeking BE/BC Primary Care physicians who desire to join a progressive, hospital-employed group practice. You'll be involved in all aspects of family medicine except obstetrics, providing clinical coverage at a new hospital-based ambulatory care center and satellite offices in St. Joseph and nearby communities. To allow flexibility for your personal life, you'll share call with other members of the Heartland Health System Department of Primary Care.

Heartland Health System is a 600-bed bi-campus regional referral center, serving 29 counties in Northwest Missouri and adjacent areas of Kansas, Iowa and Nebraska.

- Guaranteed salary of \$135,000 per year
- Medical student loan repayment options
- Malpractice insurance
- Health and life insurance
- Vacation
- Relocation expenses are provided.

For more information call Rhonda, 800-455-2480 or Heidi, 800-455-2485. Send CV to Heartland Health System, Medical Staff Development, 5325 Faraon, St. Joseph, MO 64506 or Fax to 816-271-6146.

Heartland
Health System
 EOE

©1995 NAS

Cervical Radiculopathy: Causes and Surgical Treatment

Michael D. Smith, M.D.

ABSTRACT

This article discusses the basic pathological, anatomical, and clinical problems associated with the herniated cervical disc or degenerative cervical disc disease and provides an overview of the common surgical approaches to the operative treatment of this common degenerative disorder.

Degeneration of the cervical disc is a ubiquitous process. It is present at least on a microscopic level in all individuals over 30 years of age. By the fifth decade of life, most individuals have at least some degenerative change apparent on plain radiography of their lower cervical spine.¹⁻⁴ Such radiographic findings include the presence of osteophytes (or so-called bone spurs) either anteriorly or posteriorly about the intervertebral space, disc space narrowing, degenerative changes of the zygapophyseal (or facet) joints posteriorly, spondylolisthesis (the anterior slippage of the upper vertebral body relative to the lower body) or retrolisthesis (the posterior slippage of the upper body relative to the lower body). Despite the often striking radiographic severity and universal nature of these degenerative changes, few people suffer from chronic disabling neck pain.^{5-8,16}

Most experts believe these degenerative changes arise from a loss of water content of the intervertebral disc that parallels the loss of proteoglycan matrix, which tightly binds the water molecules.⁹⁻¹¹ The loss of the matrix is dependent on the disc's genetic and biochemical composition, loading history, and the aging process. As the disc desiccates, it loses its biomechanical resiliency and becomes stiffer. This results in abnormal wear patterns in the intervertebral disc and associated secondary structures, such as the posterior facet joints. These joints then develop osteophytes as part of the reparative process.

Desiccation usually involves multiple discs in the neck, but occasionally isolated—rather than severe—disc degeneration occurs. Isolated disc degeneration is typically the result of a whiplash injury or focal disc-space

injury that occurred in adolescence or early adulthood.^{2,12-14}

In the earlier years of life, when there are relatively greater amounts of nucleus pulposus and annulus, an injury to the disc fibers can result in a herniation of disc material with subsequent compression of the spinal cord or the exiting nerve roots. This type of "soft" disc herniation is in contrast to the type that occurs later in life when enlarging osteophytes may encroach upon the spinal canal and the intervertebral nerve root canal with resulting compression of the spinal cord or the exiting nerve roots.^{15,16} The clinical and neurological features of nerve root compression may be identical, but older patients may complain more of axial neck and interscapular pain caused by local mechanical derangement of the disc.^{12,15,17,18}

DEFINITIONS

Cervical radiculopathy is defined as a functional disturbance of the cervical spinal nerve root. For this article, radiculopathy means a dysfunction of the nerve root caused by extrinsic compression from disc material or bone spur. A related condition, myelopathy, is a spinal cord dysfunction secondary to extradural compression of the spinal cord by disc herniations, osteophytes, anterior instability, or compression posteriorly from buckling of the ligamentum flavum. Myelopathy is much less frequently encountered than radiculopathy. Myelopathy may be treated by non-operative means, limited or extensive forms of anterior decompressions of the cervical cord, or by various forms of laminectomy or laminoplasty. Because of the controversial, technical, and varied treatments reported to date, consensus concerning the optimal treatment for a cervical myelop-

athy has not emerged.^{19,20} For these reasons, myelopathy is beyond the scope of this article.

PATHOLOGICAL ANATOMY

The cervical spine is a five-joint complex. This is in distinction to the lumbar spine, where there is a broad flat intervertebral disc anteriorly and two facet joints posteriorly. In the cervical spine, there is a curvilinear disc anteriorly (which allows for mobility in flexion, extension, and the lateral bending planes), two neurocentral joints laterally, and two fairly planar cephalad angulated facet joints posteriorly. All of these adaptations allow for increased mobility of the individual spinal segments.

The cervical spinal nerve roots come off the spinal cord perpendicularly. The neuroforamen, through which the spinal nerve roots run, are fairly small. The neurocentral joint, or the so-called joint of Luschka, is not a true synovial joint but rather is an area on the lateral portion of the vertebral endplates where the cup-shaped endplates impact in the presence of progressive disc space degeneration. This "joint" is just in front of the nerve root, and degenerative changes and resultant enlarging osteophytes in this area can directly compress the nerve root. These anatomical factors are important in understanding the clinical symptomatology that arises from degenerative changes off the neurocentral joint or a herniated cervical disc.

CLINICAL PRESENTATION

Herniation of a cervical disc produces symptoms because of mechanical or inflammatory irritation of the adjacent nerve root or spinal cord. Such irritation can result in radiating arm pain, sensibility loss, motor deficits, or motor tendon unit reflex changes in the particular dermatome distribution.^{12,19,21} The herniation can occur immediately after trauma or repetitive activity, or simply awaken the patient in the middle of the night. The pain can be severe, lancinating, burning, or toothache-like in quality. Numbness, tingling, or a frostbite sensation, coupled with increased pain with Valsalva maneuvers, such

as coughing or straining with bowel function, are typical. Patients often report that elevating their arms above their heads reduces pain. A sense of clumsiness or "dead arm" feelings may be present.

The most common disc space involvement is at the C5-6 level, followed by the C6-7 level, and then the

C4-5 level. Herniation of the disc between the C5 and C6 vertebral bodies or C5-6 disc results in compression of the C6 nerve root. Similarly, a C4-5 disc will compress the C5 nerve root, and so on. Table 1 summarizes the distinguishing clinical characteristics useful for making a differential diagnosis of disc herni-

Table 1

Presenting clinical characteristics

Location	Characteristics
C3-4 level C4 radiculopathy	• Relatively uncommon • No motor reflex test available • Often severe radicular pain radiating into shoulder • Motor weakness of deltoid may be present • Sensibility loss is variable • Often confused with rotator cuff disease and other shoulder problems
C4-5 level C5 radiculopathy	• Sensibility loss along the regimental stripe on the lateral aspect of the shoulder, the lateral aspect to the brachium, and occasionally, the proximal portion of the anterolateral forearm • Associated weakness of the deltoid and the external rotators of the shoulders, and perhaps some biceps weakness • Diminished biceps reflex
C5-6 level C6 radiculopathy	• Pain typically radiates around the lateral aspect of the brachium and the anti-brachium to the thumb, index, and middle fingers • Weakness of biceps and triceps • Wrist extension weakness may be noted • Diminished brachioradialis reflex
C6-7 C7 radiculopathy	• Posterior and posterolateral arm pain is noted • Diminished sensibility of the lateral aspect of the index, middle, and ring fingers, and occasionally along the medial border of the little digit • Weakness of the triceps and the pronator • Diminished triceps reflex
C7-T1 level C8 radiculopathy	• Infrequently seen • Notable for weakness of wrist flexion and grasp • Pain radiating along the ulnar border of the forearm into the lateral two digits of the hand • No motor reflex loss is detectable
T1-T2 level T1 radiculopathy	• Quite uncommon • Pain radiating to the ulnar border of the forearm, stopping short of the wrist • Weakness of the intrinsic muscles is noted • Diminished sensibility along the medial aspect of the forearm

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Pediatrics
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



ation and associated radiculopathy.^{2,7,9,22-24}

RADIOLOGICAL ASSESSMENT

A variety of radiological investigations are available to image cervical disc herniations and spondylosis.¹² Conventional radiographs add little to the diagnosis of cervical radiculopathy other than to rule out an infection, overt osteolytic process, or instability. Myelography and computed tomography or magnetic resonance imaging (MRI) are the mainstays of neuroradiologic imaging.¹⁶ Greater availability and efficiency, improved technical scanning protocols, and lower costs have eliminated most of the limitations of MRI for routine cervical problems. When all the advantages and disadvantages are considered, MRI is generally accepted as superior to myelography.

NONOPERATIVE TREATMENT

Nonoperative treatment has an important and demonstrable role in the treatment of acute soft cervical disc herniations. Nonoperative care has

limited value in cervical spondylosis when there is concomitant disc degeneration, osteophyte formation, stenosis of the central and lateral canal with resultant osseous compression of the neural elements, or dynamic instability. Most patients who respond favorably to conservative means usually report a slow but steady improvement in the severity of arm pain, numbness, and functional status, usually over the course of four to six weeks. The relief of neck and shoulder pain will take more time. In general, an improvement in the strength and sensation of the limb will parallel the patient's subjective assessment of improvement. Protracted nonoperative care is not recommended in the presence of persistent and severe pain, weakness, or major sensibility loss in those who have not shown any substantial signs of improvement beyond six weeks. Nonoperative treatment in the presence of cervical myelopathy associated with obvious cord findings also is not recommended.

The nonoperative treatments available are rest, immobilization, anti-inflammatory medication, aerobic exercise, postural awareness, spinal extensor strengthening, acupuncture, injection of local or epidural steroids, or chiropractic regimens. These measures may be employed initially with the hopes of alleviating at least some of the symptoms until intrinsic resolution of the radiculopathy has occurred and the patient is able to function independently. For more information about the advantages and disadvantages of the differing nonoperative treatment methods, the reader is referred to several recent articles.^{12,13,15,18,25,26}

OPERATIVE INDICATION

There are three principle indications for surgery on herniated cervical discs: 1) compression of the nerve root or spinal cord, 2) instability of the functional spinal unit as in spondylolisthesis or retrolisthesis, and 3) deformity. Pain alone is not an indication for surgery. If pain is associated with instability, deformity, or neurologic deficit, then an operation likely will

Creative solutions for all your health law problems



Leonard, Street and DeNard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

St. Croix Falls Wisconsin

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detail CV to:

Cathy Kortas
River Valley Medical Center
208 S. Adams Street
St. Croix Falls, WI 54024
(715) 483-3221

Family Practice Opportunity at the Family Medical Clinic in Amery, Wisconsin



Come join a dynamic ten-physician primary care practice and live in Wisconsin's beautiful lake country.

Affiliated with Ramsey Clinic, a large multi-specialty group practice, and the St. Paul-Ramsey Medical Center, a leading tertiary care center, physicians have access to immediate consultations, helicopter support, research and teaching opportunities and financial security.

Amery is a charming community of 2800, sprinkled with lakes and rivers, and located within an hour of the Twin Cities. Physicians have never left, only retired.

Please contact Aynaley Smith at Ramsey Clinic
Department of Professional Services
640 Jackson Street
St. Paul, Minnesota 55101
or by phone at 612-221-4230
or via facsimile at 612-221-8571

Ramsey Clinic

URGENT CARE OPPORTUNITIES Group Health, Inc.

Group Health, Inc. is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24 hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, or 1-800-472-4695, or send CV to: **Group Health, Inc.**, Physician Services, Attn: Ann Johnson, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



*Group Health is part of the
HealthPartners family of health plans.*

EO/AA Employer



HealthPartners



Introducing, the only auto leasing and purchasing company solely dedicated to serving the health care market.

Here's what MMBR Motor Services is committed to doing for you:

When you call us, we go to work providing free consultation to help you outline your needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and all models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle.

Or, if you prefer to sell your old car on your own, we will give you an idea of what the car is worth.

And here's something special from MMBR Motor Services. Twice during the first two years of your lease or following the purchase of a vehicle, we will arrange to have your vehicle professionally detailed, giving high resale value by keeping your

vehicle in like-new condition.

We provide complete support after the purchase. If you have a question, call



**MMBR MOTOR
SERVICES**

A MMBR Company

Owned by the members of

MMA and HCMS.

Remember, this service comes to you from MMBR, your association owned business corporation, so you can be confident in the knowledge that we have worked on your behalf to select the best company to be our partner. For your attention on your next automobile lease or purchase, call MMBR Motor Services, 623-2860, toll free 1/800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.

I would like to learn more about what
MMBR Motor Services can do for me
on the lease/purchase of my next vehicle.

Name _____

Address _____

City _____ State _____ Zip _____

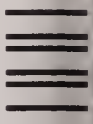
Please contact me at my ☐ Home ☐ Office

Phone number _____

I plan to ☐ lease ☐ purchase a new vehicle

Within ☐ 3 months ☐ 6 months ☐ 12 months

MN/MED



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761

ANNOUNCEMENTS

• • • • •

IMPORTANT: You MUST POST MEDICAL RECORDS NOTICE

FINAL NOTICE IS NOW AVAILABLE

A new law requires health care providers to include a medical records notice with the patient bill of rights or display it prominently in their offices.

The Minnesota Department of Health has published the final "Notice of Patient Access to Health Records Practices and Rights" in the February 13 *State Register*. This notice tells patients how they can obtain copies of their health records and informs them that, at times, their health records may be disclosed without their consent. If you would like a copy of this notice, write to the Minnesota Health Information Clearinghouse, Minnesota Department of Health, PO Box 64975, St. Paul, MN 55164-0975.

• • •

MMA MEDIA TOUR CONTINUES

The MMA continues to build statewide support for the MMA Quality and Coverage bill. On March 16, Timothy Crimmins, M.D., chair of the MMA Board of Trustees, and Mark Vukelich, MMA director of communications, traveled to Duluth, where they met with editors of the *Duluth News Tribune*, attended a meeting of the Lake Superior Medical Society, and gave interviews to WDIO-TV and KDAL-radio.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Advances Quality and Coverage Goals

In a major victory for the MMA, the Senate Health Care Committee on March 9 adopted amendments that bring the bipartisan Legislative Oversight Commission's bill closer to the MMA Quality and Coverage bill, S.F. 235/H.F. 254. The Senate LOC bill, S.F. 845, now calls for repeal rather than suspension of the RAPO fee schedule and includes the key utilization review (UR) provisions of the Quality and Coverage bill. These provisions are designed to make health plans accountable for preserving quality of care in a competitive marketplace.

The Senate LOC bill, drafted by the bipartisan group of nine legislators that spearheads state health reform efforts, includes these amendments:

- requires plans to disclose UR criteria to patients and providers upon request;
- requires plans to cover out-of-network emergency care;
- requires UR firms to develop clinical criteria with involvement from actively practicing physicians and to review and update criteria each year;
- prohibits plans from offering incentives to providers for denying health care services to enrollees;
- requires all health plans to participate in state risk adjustment;
- prohibits plans from designing networks in a way that discourages enrollment by people with expensive health needs;
- makes Minnesota's UR law apply to workers' compensation;
- requires weekend UR, but not

24-hour UR.

The adoption of MMA amendments is significant because the LOC bill will be the vehicle for MinnesotaCare changes. The MMA is pressing for similar changes in the House version of the LOC bill.

Senate committee action came after three days of hearings on the major health reform bills—the MMA Quality and Coverage bill, the IR Caucus bill, and the LOC bill. On the first day of hearings, Timothy Crimmins, M.D., chair of the MMA Board of Trustees, gave an overview of the MMA bill and successfully urged legislators to add the amendments to the LOC bill calling for repeal of RAPO and for the utilization review provisions. Crimmins also urged the committee to adopt the following measures, which are now proceeding as separate bills:

- a higher cigarette tax to fund MinnesotaCare,
- public safety measures,
- tort reform,
- medical savings accounts.

He also pushed for the point-of-service option requirement and repeal of the 2 percent provider tax, key MMA objectives that are not included in the amended LOC bill and not proceeding as part of separate legislation. The MMA will continue to urge legislators to add these provisions as the LOC bill moves through committees.

The Quality and Coverage bill's Senate author, Sheila Kiscaden, IR-Rochester, who offered the UR amendment, described the MMA bill

Q&C continued on page 34

Q&C continued from page 33

as philosophically similar to the LOC bill in its "market-based, less regulatory approach to health care reform." She fielded several questions from lawmakers who were concerned about passing helmet laws at time when constituents say they want government off their backs. Kiscaden said she felt the same way until she toured the rehabilitation unit for head injury patients at St. Mary's Hospital.

Testifying in favor of the LOC bill, Tom Swain, chair of the Minnesota Health Care Commission, called the uninsured or "free-rider" penalty, which is also in the MMA bill, "the most critical element of this year's proposal." He said that 31 percent of the uninsured—124,000 individuals, mostly young single men—earn more than \$20,240, or 275 percent of the federal poverty level, but choose not to buy insurance. "Until we can persuade them to become part of the insurance pool, we can't move closer to universal coverage," Swain said. "And we can't have insurance reform without universal coverage or people will wait until they're wheeled into the emergency room and sign up for insur-

ance on the spot." Both the LOC and MMA bills set less of a penalty than the commission recommended, which was 2.2 percent of gross income or \$500 a person. With this penalty, the commission expected 20 percent of the uninsured to sign up. A penalty as high as 10 percent of gross income would bring more than 90 percent on board, Swain said.

Swain argued against medical savings accounts (MSAs), which are included in the MMA and IR bills, but not in the LOC bill. He said that MSAs could discourage people from seeking preventive care and would not move the state closer to universal coverage. Money in an MSA could be compounded or withdrawn, but it would not swell the insurance pool.

Speaking for the governor's administration, Ann Barry, acting commissioner of health, told the committee she was "generally supportive of the LOC bill," but she recommended repeal rather than suspension of the RAPO fee schedule and opposed expanding eligibility for the MinnesotaCare program partly because of the uncertainty of continued federal funding. The governor has said that expanding MinnesotaCare eligibility would be reason enough to veto the entire bill.

The amended LOC bill passed the Senate Health Care Committee on a voice vote and was referred to the Senate Commerce Committee. The Commerce Committee adopted amendments that repeal the LOC bill's five cost-sharing options for the basic benefits set and repeal all insurance reform provisions, including the move toward community rating. The LOC bill originally called for delay of insurance reforms until universal coverage was achieved. The amended bill passed the Commerce Committee and was referred to the Government Operations Committee.

To speed the process and meet committee deadlines, the LOC data provisions, which are in line with MMA goals, have been removed from the LOC bill and introduced as a separate bill, which was referred to the Senate Data Privacy Committee.

In the House, the MinnesotaCare Division of the House Health and Human Services Committee is considering the health reform bills but has not taken action. The MMA is concentrating on bringing the House LOC bill closer to the MMA Quality and Coverage bill. • • • • •

.....

QUALITY AND COVERAGE BILLS

CIGARETTE TAX BILL INTRODUCED

At a news conference March 13, Sen. Len Price, DFL-Woodbury, and Rep. Becky Lourey, DFL-Kerrick, introduced a bipartisan bill, S.F. 1080/H.F. 1321, that would raise the cigarette tax 40 cents a pack beginning July 1, 1995. This is similar to the Quality and Coverage proposal but it would raise the tax one time instead of raising it each year for five years.

The cigarette tax bill would raise funds for the MinnesotaCare program and at the same time discourage young people from starting to smoke. Five cents of the 40-cent increase would be used for a

youth smoking prevention program and the remaining \$106.6 million would be dedicated to the health care access fund.

"We need funds to combat the onslaught of advertising that targets young people," Price said. "Children and teenagers nationwide constitute 90 percent of all new smokers." Statistics show that a 10 percent increase in the cigarette tax will decrease youth smoking by 12 percent. Supporters of the tax stressed the high stakes involved in stopping young people from getting hooked on a substance more addictive than heroin. "Smoking kills an estimated 435,000 Ameri-

cans each year—more than alcohol, heroin, crack, car and airplane accidents, homicides, fires, suicides, and AIDS combined," said Lourey.

Sheila Kiscaden, IR-Rochester, one of the co-authors, said the bill will not only serve as a deterrent to smoking but it will also help pay for the health care costs directly related to smoking. "The Minnesota Department of Health has estimated that health care costs for smoking-caused diseases were nearly \$470 million for 1992. This amounts to \$1.29 for every pack of cigarettes sold in Minnesota—or \$107 out of every Minnesotan's pocket." Increasing the tobacco tax will

.....

QUALITY AND COVERAGE BILLS

benefit businesses by lowering the smoking rate. Smokers have twice as many job-related accidents as nonsmokers. They lose about 30 minutes a day in productivity due to smoking, use 50 percent more sick leave, and use the health care system 50 percent more than nonsmokers.

The tobacco tax bill is strongly supported by the Minnesota Medical Association, the Smoke Free 2000 Coalition, and the Tobacco Tax Coalition. Its co-authors include Sens. Steve Dille, IR-Dassel, John Hottinger, DFL-Mankato, and Sandy Pappas, DFL-St. Paul, and Reps. Lee Greenfield, DFL-Minneapolis, Dave Bishop, IR-Rochester, Andy Dawkins, DFL-St. Paul, and Don Ostrom, DFL-St. Peter.

Despite the fact that a statewide opinion poll found nearly 65 percent of Minnesotans support a higher tax on tobacco, this bill faces an uphill battle. Republicans have vowed "no new taxes" and DFLers fear being

labeled "tax-and-spend Democrats." Reporters at the news conference asked supporters whether the bill really has a chance of passing in a year when the governor has threatened to veto any tax increase. Price said he would advise the governor: "Keep your options open. You could be a hero by signing a bill into law that would save the state a lot of money and do a great deed for the children of Minnesota." (See related articles in *Minnesota Medicine*, pages 10, 19, 23.)

.....

MEDICAL LIABILITY REFORM BILL INTRODUCED

The medical liability reforms in the MMA Quality and Coverage bill have been introduced as separate legislation, H.F. 589-Leppik/S.F. 578-Hottinger. These bills cap non-economic damages at \$250,000, adopt a sliding-scale cap on attorney contingency fees, use periodic

payments for large awards, adopt changes to joint and several liability, and provide equal access by the defense and the plaintiff to the physician experts.

.....

PUBLIC SAFETY BILLS ADVANCE

The MMA supports the bill H.F. 471-Greenfield, which would make failure to wear a seat belt a primary offense, allowing a police officer to stop someone for that reason alone. Unlike a similar provision in the Quality and Coverage Act, this bill would not increase the \$25 fine to \$100. The seat belt bill passed out of the House Judiciary Committee and was referred to the House Transportation Committee. The bill S.F. 605-Vickerman, which would require snowmobilers to wear helmets, has received two hearings in the Senate Environment and Natural Resources Committee and is scheduled for a third hearing.

Physicians Play Important Role in Preventing Brain Injury

.....

PHYSICIANS CAN HELP prevent traumatic brain injuries by giving patients these important messages:

- Wearing a helmet is the most effective way to prevent brain injury and to be safe on a bike or on rollerblades.

- Crashes happen anywhere, even in quiet neighborhoods and on sidewalks.

Encourage Helmet Use

- Reward the children who tell you they wear helmets by giving them small prizes, such as stickers for their helmets.

- Write a bicycle helmet prescription for each child whom you see at your clinic. This will help reinforce the importance of pro-

tecting their brains.

- Remind parents to model safe behaviors. Parents should wear bicycle helmets every time they ride.

- Place bicycle helmet posters and colorful, child-sized helmets in your reception area. Encourage children to try on the helmets.

Answer Questions

- Be prepared to answer the common question, "Which helmet should I buy for my child?" Any helmet that meets an ANSI, ASTM, or Snell safety standard (the labels will be on the box and inside the helmet) and that fits well is adequate.

- Although multi-impact helmets are available for rollerblading, bicycle helmets can be substituted.

- Suggest that parents have their

children help pick out their helmets. If children like a helmet, they will wear it.

Free Packet Is Available

Call for a free packet of educational materials to assist you in promoting the use of bicycle helmets. The packet was developed by the Minnesota Injury Prevention Program, in conjunction with the Minnesota Medical Association, Minnesota SAFE KIDS Coalition, and the Minnesota Chapter of the American Academy of Pediatrics Injury and Poison Prevention Committee. To request a packet, or for additional information, contact the Minnesota Injury Prevention Program, Minnesota Department of Health, 717 SE Delaware Street, Minneapolis, MN 55440, or call 612/623-5285.



Viewpoint

• • •

Timothy J. Crimmins, M.D.
Chair, MMA Board of Trustees

How to Succeed in a Competitive Market

The MMA has been urging state legislators not to over-regulate the health care system, to let the competitive market work to hold down health care costs. Our arguments are being heard. In the wake of the failure of national reform efforts and a shift in public mood away from regulation, it seems likely the state will back off on its ambitious plans to regulate the health care market in favor of a more market-based approach.

This is good news for physicians. But an increasingly competitive market will present its own set of professional challenges.

Business experts say everybody looks good in a rising market. During the 1970s and 1980s when indemnity insurance paid for most health care services, we physicians could concentrate on treating our patients and didn't have to worry too much about the business aspects of our practice.

Now, however, many of us practice in a mature marketplace where the supply of medical services exceeds demand. Large, powerful purchasers are looking closely at the bottom line. Risk-bearing insurance companies operate like wholesale purchasers, negotiating on behalf of their enrollees for the best deals and buying health care services at discount prices.

To be leaders in this new marketplace, it's not good enough to be highly skilled in treating patients; we have to be savvy about business management as well. Our main concerns will always remain the same. What is best for our patients? How can we provide them the services they need? But in the future, we may not provide those services in the same way we do now. We may supervise the work of others rather than doing everything ourselves. As medicine becomes more businesslike, we will have to choose our personal role in the marketplace and develop a strategy for success.

In business, there are three major roles: the producer, the manager, and the leader. In the past, we physicians have played all three roles; we have treated patients, supervised staff, and decided which services to provide. In a more competitive market, however, playing multiple roles will be more difficult. Success in business requires skills in managing people, organizing offices, and developing strategic plans. We have to decide where we want to fit in this picture. Do we want to develop these new skills? Or would we rather accept the role of producer and concentrate on practicing medicine? Do we want to be a producer, or a producer/manager, or a producer/manager/leader? Each role calls for quite different expertise.

If we choose the role of corporate leader, we will be expected to see the "big picture" and make sure services are suited to the market. We will have to develop a vision for the future, a strategy for success.

Looking at successful business techniques may be useful. Companies that thrive in a competitive market usually concentrate on one of three strategies: loyalty, innovation, or value. They may:

1) provide a high level of service, concentrate on pleasing their customers and building loyalty;

2) provide cutting-edge technology, the latest and most advanced techniques, and concentrate on research and development; or

3) deliver high value, good service for the price. This Wal-Mart, one-size-fits-all approach depends on high volume and operational efficiency.

Concentrating on a single strategy—rather than trying to excel at all three—may give an edge in the medical marketplace. We can learn valuable lessons from corporate America.

But medicine will never be just a business; it is a profession with high ethical standards. As our patients' advocates, we physicians are guided by different rules than business executives. Even in a highly competitive market, profit can never be our only motive. Naturally, we want to receive fair reimbursement for our services, but we can't charge whatever the market will bear, or exploit the sick.

Our strategy for success must incorporate not only the lessons of business, but also the high ideals of our profession. When physicians develop the overall philosophy, there will be a high level of altruism. Patients will be told about any services their plan won't cover. Bedside rationing will be avoided. There will be no financial rewards for withholding services; services will be withheld only when they are not medically indicated or not available. The collegiality of our distinguished profession will be maintained. • • • • •

LEGISLATIVE NEWS

CHIROPRACTIC BILL REFERRED TO SENATE HEALTH COMMITTEE

Testifying for the MMA against a bill that would authorize chiropractors to perform the mandatory biennial physical exam for truck drivers, Paul E. Brown, M.D., asked members of the Senate Transportation and Public Transport Committee: "Who would you prefer to examine you for an undiagnosed serious condition—a chiropractor who has limited classroom training in non-muscular skeletal conditions, or a residency-trained, primary care physician who regularly sees a wide variety of conditions?"

Brown told lawmakers that chiropractors have neither the training nor the experience to perform an adequate exam. "Learning the mechanics of a physical exam is not difficult," said Brown, an internist in Waconia. "But being able to detect the subtle signs of diseases such as alcoholism and diabetes is an entirely different matter."

Chiropractors' training takes place in the classroom and focuses mainly on treating backaches, neck pain, and headaches—conditions that make up only a small portion of the truckers' examination form. On average, chiropractic students see two patients suffering from any illness other than a musculoskeletal complaint. In contrast, third- and fourth-year medical students see many patients with a wide variety of medical conditions. They learn from experienced specialists in surgery, cardiology, and neurology, as well as primary care. After graduation, they become residents in teaching hospitals for three or more years. Chiropractic students go directly into practice.

There is a wide gap between chiropractors and physicians in experience as well as training. The American Chiropractic Association surveys show that 87 percent of chiropractic

patients are seen for musculoskeletal complaints. Another survey put this figure at 94.6 percent. In contrast, physicians see patients with a wide range of systemic diseases.

The Minnesota Chiropractic Association initiated this bill in response to a Minnesota Department of Transportation (DOT) statement that a physical examination performed by a chiropractor does not satisfy the federal requirement for an annual exam for truck drivers. The truckers' exam form must be authorized by a person with an M.D. or a D.O. degree.

Chiropractors dispute the DOT's interpretation of existing law. The bill's author, Sen. Jim Vickerman, DFL-Tracy, suggested to the committee that chiropractors don't really need this bill because they already have the authority to sign the truckers' exam form. Sen. Florian Chmielewski, DFL-Sturgeon Lake, the committee chair, disagreed. He said that since it is unlikely that the DOT will change its interpretation of the law, the chiropractors do need this bill if they are to perform the exams.

Because objections to the bill, S.F. 333-Vickerman, center on health care rather than transportation issues, the committee referred this bill to the Senate Health Care Committee, where it is expected to undergo tough scrutiny. The MMA will continue to strongly oppose this bill.

SENATE VULNERABLE ADULT BILL IMPROVED

The MMA arguments have prevailed in the Senate. The Senate Crime Prevention Committee on March 9 adopted a number of amendments that improve the Senate version of the Vulnerable Adult bill. The committee deleted a provision that

would have allowed hearsay testimony of mentally competent individuals who are defined as "vulnerable adults" to be admitted as evidence in any civil or criminal action. The MMA has worked behind the scenes arguing that this provision was unfair, raised constitutional concerns, and was unnecessary. Current law already allows hearsay evidence of children and the mentally impaired to be admitted. The committee tightened language regarding criminal prosecution for neglect; the amended bill makes it clear that the act or omission must constitute "a conscious disregard for danger to human life and reckless indifference to the risk of harm." Failure to report abuse of a vulnerable adult was changed from a gross misdemeanor to a misdemeanor. Responding to concern that this bill's reporting requirement would discourage victims of domestic abuse from seeking help, the committee adopted an amendment intended to make it clear that abuse that occurs before a person comes to the hospital or clinic does not have to be reported unless the victim is unable or unlikely to report maltreatment without help because of mental or physical impairment or emotional status. The MMA is working to attach similar amendments to the House bill.

PHYSICAL THERAPISTS SEEK OWN LICENSING BOARD

The Physical Therapy Association has introduced a bill that would establish a licensing board with disciplinary authority over physical therapists. Currently, the Board of Medical Practice registers and disciplines physical therapists.

LEGISLATIVE NEWS

BILL WOULD EXPAND UMD TO FOUR-YEAR MEDICAL SCHOOL

The University of Minnesota-Duluth School of Medicine is promoting a bill, H.F. 690, introduced by Rep. Roger Cooper, DFL-Bird Island, that would expand its two-year program to a four-year program. The legislation would also increase the number of medical students participating in the Rural Physician Associate

Program, establish a locum tenens program at UMD for four rural pilot projects, and ask the University of Minnesota to apply for an Area Health Education Center grant from the federal government.

At a hearing February 28, the MinnesotaCare Division of the House Health and Human Services Committee heard testimony supporting the UMD bill from Ronald

Franks, M.D., dean of the UMD School of Medicine, Nancy Baker, M.D., president of the Minnesota Academy of Family Physicians, and William Brody, M.D., Ph.D., provost of the School of Health Sciences at the University of Minnesota. The MinnesotaCare Division took no action on this bill but intends to deal with it as part of its budget bill.

NATIONAL NEWS

CONGRESS PASSES CAP ON NON-ECONOMIC DAMAGES

The MMA played a key role in the victory on liability reform in the U.S. Congress. Joining the AMA and other state medical and specialty societies in a major lobbying effort, the MMA contacted the Minnesota congressional delegation and enlisted the help of the MMA legislative network in building support for medical liability reform. Rep. Jim Ramstad, R-Minnesota, received 1,000 letters, which ran 100-1 in favor of liability reform, and then signed on as a co-author of the Cox-Geren amendment to the Product Liability Bill. This amendment sets a cap of \$250,000 for pain and suffering in all medical liability lawsuits. The U.S. House of Representatives approved the Cox amendment by a vote of 247 to 171, and the amended bill passed the House 265 to 161 on March 10. Minnesota Reps. David Minge, DFL, Collin Peterson, DFL, and Gil Gutknecht, IR, supported the amendment.

The MMA has written to Minnesota Sens. Paul Wellstone, DFL, and Rod Grams, IR, urging them to support the cap on non-economic damages in the Senate bill.

WELLSTONE INTRODUCES INSURANCE BILL

Sen. Paul Wellstone has introduced a bill that would outlaw the practice of denying health insurance coverage to victims of domestic abuse. The 1994 MMA House of Delegates passed a resolution calling for the MMA to oppose denial of insurance coverage to domestic violence victims. At the December AMA Interim Meeting, the MMA delegation forwarded a similar resolution to the AMA House of Delegates, and it was adopted.

COURT MAKES IT EASIER FOR EMPLOYERS TO CANCEL BENEFITS

The U.S. Supreme Court has ruled unanimously that standard benefits plan wording that gives a company the right to amend the plan is valid. The court ruled March 6 in favor of Curtiss-Wright Corp., which canceled health benefits to retired non-union employees of a New Jersey plant it closed in 1983.

AMA INTRODUCES PHYSICIANS CAPITAL SOURCE

The AMA has launched a new program to help physicians create their own managed care networks.

The Physicians Capital Source will provide physicians with access to business, legal, financial, and managed care experts who can help them develop business plans and link them with potential capital sources.

The AMA will give participants a booklet, "Developing a Business Plan: A Physician's Guide," to help them with the first step—completing a detailed Request for Information. The RFI serves as a blueprint for developing a business plan. Physicians whose plans are approved are linked to potential capital sources that can meet their short- and long-term financing needs.

Members of the Physicians Capital Source Advisory Committee offer participants advice during the application process. Committee members include experts in banking/investment banking, venture capital, technical systems (management information and administrative systems), physician governance, law and accounting, and managed care strategy development. They also evaluate completed business plans to determine if they are viable.

For more information, call the AMA's Managed Care Help Line at 800/AMA-1066.

ANNOUNCEMENTS

CANCER PAIN MANAGEMENT SEMINAR

The Minnesota Medical Association and the Minnesota Board of Medical Practice are jointly sponsoring a seminar on cancer pain management.

After attending the seminar, participants should be able to implement the basics of whole patient management, pharmacological tools, and clinical techniques; to manage pain in the chemically dependent; and to identify possible complications. Emphasis will be on the knowledge and skills required for successful cancer pain management in a primary care setting. Faculty members include experts on spiritual care, pharmacology, oncology, and addiction medicine.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The MMA designates this CME activity for 2.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Dates and locations for the remaining seminars are as follows: April 19, Fergus Falls Community College; April 26, Hibbing Community College; May 2, Lakewood Community College, St. Paul; and May 4, Hennepin Technical College, Eden Prairie.

Each seminar begins with a buffet at 5:30 p.m. The registration fee is \$25. To register, please call the BMP at 612/642-0538.

AMA President-Elect Calls for Cultural Competence in Health Care

Is the medical community culturally competent? AMA President-elect Lonnie Bristow, M.D., who was in the Twin Cities February 24 to speak at a seminar on cultural diversity, said, "This seminar brings us closer to a time when we can answer with a definite 'yes.' We will have achieved cultural competence when we all can understand and appreciate and work with people of difference cultures." Otherwise, American health care faces a "grim future," he predicted. Bristow is the first African-American AMA president.

Explaining his deep commitment to cultural diversity, Bristow said that when he was a boy growing up in Harlem, his job was to walk his mother home at night from the hospital where she worked as an emergency room nurse. While he waited for his mother, he saw the ER doctors and nurses in action and they became his heroes. These caregivers were the "epitome of diversity," a group that included African-Americans, South Americans, and Italians. He realized that medicine was not limited to one race, and he grew up wanting to be just like the caregivers he saw working miracles every night. His enthusiasm for his profession has not waned. Bristow says medicine is still a "wonderful adventure."

It's important to increase the number of minority physicians, Bristow said. In addition, individual physicians must become more aware of the way cultural differences affect health care. An article in *JAMA* reported that Hispanic patients treated for broken bones received half as much pain medicine as white patients. Why? Because Hispanics are less likely to complain about pain, and the caregivers were unable to recognize the signs of pain in those who were culturally different from themselves. "We can't understand the nuances of every culture, but we

can't stop *trying* to understand," Bristow said. "A genuine concern for our patients will override any inadvertent errors." The seminar, sponsored by Hennepin County Medical Center, Hennepin County Medical Society, the University of Minnesota, and United Way of Minneapolis, included breakout sessions that explored various cultures.

Statistics point to a lower standard of care for minorities. Bristow cited the findings of a Health Care Financing Administration report about disparities in access to Medicare.

- Elderly African-Americans are at high risk of not getting appropriate, timely health care.

- Fewer black women on Medicare receive mammograms, and their breast cancer rate is higher.

- Doctors are less likely to tell pregnant black women to stop smoking. Black women tend to have more low-birthweight infants.

- The death rate for most of the leading causes of death is higher for African Americans.

Aggravating the problem of disparities in care, "changes of seismic proportions are shaking health care," Bristow said. Forces are chipping away at the relationship between the doctor and patient, a relationship he called "as important to healing as any medicine." Minority physicians may be dropped from managed care networks because their poor minority patients tend to be sicker and more expensive to treat. Medicare is in danger of massive cuts that could reduce quality of care. Bristow criticized "boardroom bureaucrats who put profits above patient care, a society that decries violence but is unwilling to outlaw the cause of violence, and politicians who would balance the budget on the backs of physicians and their patients."

• • • • •

MINNESOTACARE NEWS

HCFA EXPECTED TO APPROVE PART OF STATE WAIVER

The Minnesota Department of Human Services (DHS) and the U.S. Health Care Financing Administration (HCFA) of the Department of Health and Human Services have reached agreement on the budget neutrality issue, which has been the chief stumbling block to federal approval of the state's request for a cosmic waiver. The state was not able to win approval for the following aspects of the waiver:

- Medical Assistance coverage for patients in MinnesotaCare not otherwise eligible for MA;
- Six-month guaranteed eligibility for MA recipients enrolled in managed care.

After HCFA rejected an initial proposal, DHS submitted a counter proposal, shifting these two aspects to Phase 2, during which a more detailed proposal will be worked out and approval for implementation will again be requested.

Although terms and conditions still must be agreed upon, Maria Gomez, commissioner of human services, said she is "very optimistic" that HCFA will approve the revised waiver now that the most controversial aspects have been moved to Phase 2. HCFA has indicated it will approve the following aspects:

- federal financial participation for all the children in MinnesotaCare;
- retroactive funding for General Assistance Medical Care recipients later found to be eligible for Medical Assistance;
- one-month rolling eligibility for individuals enrolled in managed care contracts;
- establishment of a pre-paid dental care project to improve access; and
- the opportunity for pregnant women to stay with other family members in MinnesotaCare but

receive federal financial participation for their care.

HOW MUCH DOES UNCOMPENSATED CARE COST?

In 1993, Minnesota hospitals and physicians provided about \$218 million worth of uncompensated care. This number is important to state planners because they want to know how much could be saved by extending health insurance coverage to the approximately 400,000 uninsured people in Minnesota.

Total physician expenses for 1993 were estimated at \$3.6 billion. Physician clinics reported that 2.9 percent of those expenses, or approximately \$104.4 million, was due to uncompensated care. Uncompensated care includes charity care and bad debts. The Minnesota Department of Health (MDH) believes this estimate is low. The Minnesota numbers are based on the expense and revenue reports that physician clinics were required to submit for the first time last year.

Minnesota hospitals reported \$113 million in uncompensated care in 1993, representing 2.9 percent of total operating expenses. Compared with other states, Minnesota ranks among the lowest in its rate of uncompensated care. This is due in part to the low rate of uninsured in Minnesota compared with other states, according to the MDH.

HOW MUCH DOES MINNESOTA SPEND ON HEALTH CARE?

Based on revenue and expense data collected by the Minnesota Department of Health, total personal health care spending for the state in 1993 was \$14.1 billion, an increase of 8.2 percent over 1992 spending. This is higher than the 1993 national spending increase of 7.9 percent.

Why is Minnesota spending more?

Other states are copying us and introducing managed care methods, according to George Halvorson, the Minnesota Council of HMOs' representative on the Minnesota Health Care Commission. Halvorson predicted that spending in other states would continue to drop dramatically in the next few years as managed care gains a foothold. Other reasons for higher spending in Minnesota are the lower rate of uninsured, the number of people from outside the state seeking care at Minnesota hospitals and clinics, and the comprehensive benefits sets in both the public and private sectors.

While the spending increase is higher in Minnesota than it is nationally, premium costs are lower. Halvorson said that Minnesota employers pay much less for health insurance—\$1,000 to \$2,000 less per employee—in Minnesota than they do in other states. The move toward reform has created market forces that are already reversing the upward trend of health care prices in Minnesota.

The Monitor

APRIL 1995

...

PRESIDENT*Andrew J.K. Smith, M.D.***CHAIR, BOARD OF TRUSTEES***Timothy J. Crimmins, M.D.***CHIEF EXECUTIVE OFFICER***Paul S. Sanders, M.D.***DIRECTOR, COMMUNICATIONS***Mark S. Vukelich***EDITOR***Lorrie Holmgren*

...



Quality Medicine Quality Community

Heartland Family Practice is a six physician group located in thriving St. Cloud, Minnesota. As part of this progressive group, you will practice in a newly constructed clinic just one-half mile from St. Cloud Hospital.

St. Cloud is Minnesota's fastest growing area, conveniently located between the Twin Cities and prime Minnesota lake regions. Enjoy our family oriented community with its university atmosphere and excellent recreational offerings.

Please send CV or call:
John Schnettler
Physician Recruiter
St. Cloud Hospital
1406 6th Avenue North
St. Cloud, MN 56303
800-835-6652

Heartland
FAMILY PRACTICE

WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient, Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE

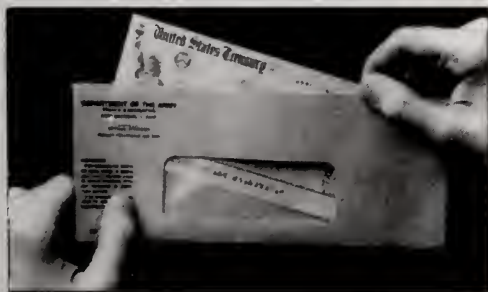


Contact: Physician Placement Office
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor.

CALL COLLECT CPT. RICK OTTO
612-854-7702

ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®

RADICULOPATHY

continued from page 30

help. Additionally, approximately 30% of asymptomatic individuals over age 30 will have significant radiographic findings of degenerative disc disease. These findings include herniations, disc space narrowing, internal desiccation of the nucleus, and stenosis of the intervertebral nerve root or central spinal canal.⁵ Therefore, it is important to correlate the distribution and intensity of the cervical and arm pain with the location, laterality, and extent of cord or nerve root compression before recommending surgery.

By far the most common indication for surgery is compression of the

nerve root or spinal cord. This is typically caused by herniation of soft disc material into the posterolateral aspect of the spinal canal, with compression of the take-off of the exiting nerve root. If the disc is more central, it can result in some degree of spinal cord compression. Most disc herniations result in a rather typical and predictable clinical picture of pain, paralysis, and reflex changes.

The second most common indication is instability. As the disc degenerates, biomechanical changes occur, including alterations in the posterior facet joints, which are critical to maintaining anterior-posterior stability of the spine.

The least common indication is deformity, which typically occurs in

patients with marked loss of disc height over multiple levels and results in loss of the usual cervical lordosis and progressive kyphosis. In turn, this causes draping of the spinal cord and traction of the nerve roots over the degenerative spurs anteriorly. Correction of severe kyphosis is important, particularly in individuals with myelopathy, in order to optimize clinical and neurological recovery.

TYPES OF OPERATIONS

There are three basic operations for cervical radiculopathy: 1) anterior cervical discectomy and fusion 2) anterior cervical discectomy without fusion, and 3) posterior laminoforaminotomy.

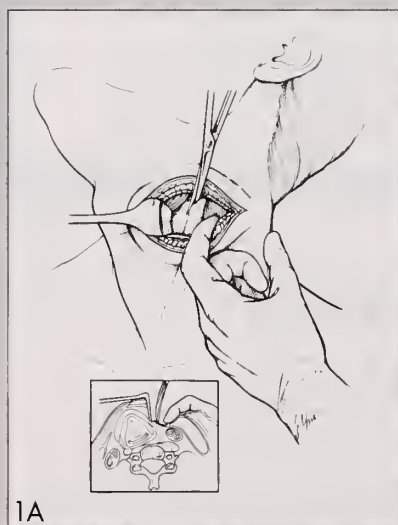


Figure 1—a series of line drawings illustrating the anterior approach, discectomy, and fusion.

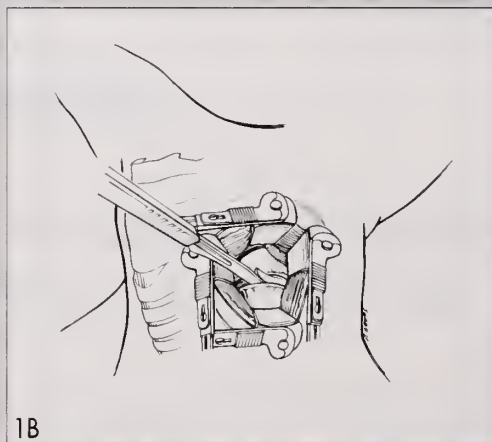


Figure 1A (top left)—a transverse incision is used for cosmesis. A small incision can be made if the investing fascial layers are divided and the surrounding structures carefully mobilized. The inset demonstrates the approach just medial to the carotid bundle and lateral to the tracheo-esophageal groove.

Figure 1B (top right)—self-retaining retractors are placed for ease of exposure and protection of the vessels and the trachea and esophagus. The disc annulus is incised, and the disc space developed.

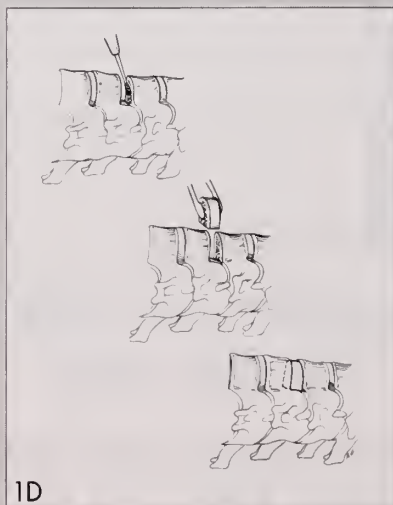
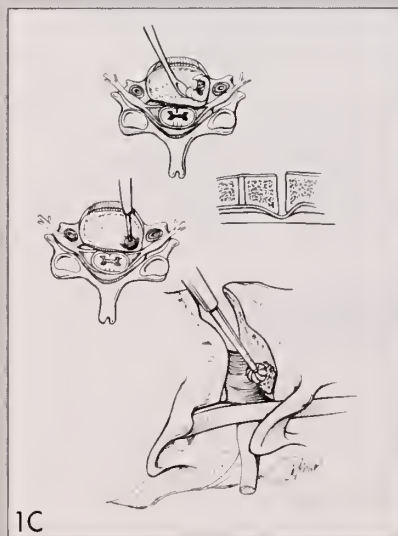


Figure 1C (bottom left)—the soft disc material is removed with fine curettes; the hard degenerative bone spurs are removed by first thinning their substance with a high-speed air-driven drill, and then prying the residual material away from the spinal canal with curettes. Caution is needed with these maneuvers because of the proximity of the nerve root, spinal cord, and vertebral artery.

Figure 1D (bottom right)—a burr is used to grind the disc space to provide a flattened surface for good approximation and mating of the iliac crest bone graft to the corresponding endplate to be fused.

Anterior decompression and fusion has been described by various authors.^{12,18,19,27-30} (See Figure 1.)

After the procedure, the patient is immobilized in some form of rigid brace. This helps relieve postoperative muscle spasm and protects the bone graft while it heals. Most patients wear the orthosis for six weeks. Radiographs are then taken and if the fusion looks satisfactorily rigid, external immobilization is discontinued and a short course of physiotherapy is recommended to restore range of motion and improve isometric strengthening. Patients usually return to work gradually starting at eight weeks after surgery.

The effectiveness of anterior discectomy without fusion has been questioned recently because of the potential for persistent symptoms.³¹⁻³³ Numerous studies have shown that fusion is integral to the relief of neck pain.³⁴ In addition, restenosis of the intervertebral nerve root canal secondary to progressive disc space collapse can occur if the disc space does not stabilize. Most studies show that patients do have persistent symptoms if they do not develop a spontaneous fibrous or osseous union over the operative levels. For these two reasons, this procedure has fallen out of favor in most parts of the country.

A variant of discectomy without fusion is an anterior microdiscectomy.³⁵ However, not enough well-controlled perspective studies exist to document its effectiveness, and it is not a frequently performed procedure.^{15,18,26,36,37}

Fundamentally, the anterior approach has the benefits of a direct disc resection and direct neural decompression without extensive manipulation of the spinal cord or the nerve roots. Because the approach involves surgical dissection about the trachea, esophagus, recurrent laryngeal nerve, and common carotid neurovascular sheath, an anterior approach (rather than a posterior approach) may place these structures at risk. Several recent studies suggest an incidence of such adverse occurrences of less than 1%.^{12,18,36,38,39}

The posterior approach has the benefits of being extensile and safe and requires less operating time. However, central disc herniations cannot be safely excised, and variable relief of specific neck pain has been reported. Posterior fusions are not typically done with the disc fragment excision. (See Figure 2.)

ANTICIPATED RESULTS

Anterior or posterior surgery for the herniated cervical disc can be suc-

cessful if the criteria for selection of the operative candidate is strictly followed. These criteria include a history of cervical and arm pain, a physical examination demonstrating a dermatomal distribution of pain, sensibility loss, motor weakness, and/or alteration in deep tendon reflexes. The criteria also include an objective imaging study, such as MRI or myelogram and computed tomography scan, of the cervical spine that demonstrates a disc herniation or osteophyte formation and stenosis of a level of the spine that correlates with the clinical complaints and physical examination. In this situation, the results of surgery are gratifying. Patients with one-level disc disease have the most durable results, while those with multiple levels of involvement tend to have lingering symptoms.

Those who smoke have lower fusion rates than nonsmokers. Additionally, those who smoke have a higher likelihood of requiring reoperation for adjacent disc herniations or persistent pain than nonsmokers. Workers' compensation claims and pending litigation tend to reduce the success of operative treatment.

Most studies report essentially equivalent relief of arm pain from either the anterior or posterior ap-

Figure 2—a series of line drawings illustrating the posterior foraminotomy.

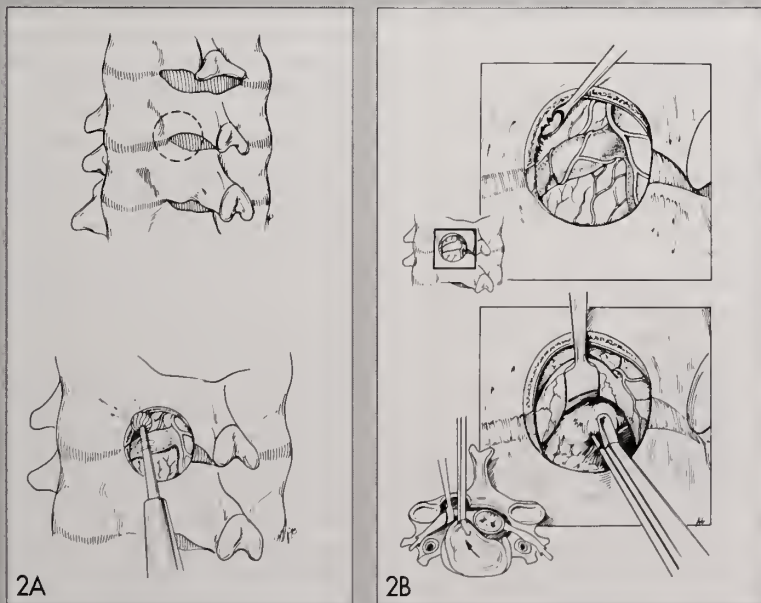


Figure 2A (far left)—the amount of exposure of cervical lamina and facet joint necessary for posterior discectomy and decompression of the nerve root. The drawing demonstrates thinning of the lamina with a burr for lateral exposure of the spinal canal and partial nerve root decompression.

Figure 2B (left)—a close-up sketch reveals further removal of the soft tissue of the facet capsule and ligamentum flavum for more comprehensive root decompression. If a fragment of disc is suspected, the nerve root may be gently retracted to achieve access for disc removal.

proach; anterior procedures may have some benefit in long-term relief of the associated neck pain. The greater relief of neck pain by the anterior approach is believed to be due to stabilization of the degenerate disc process by fusion. In comparable groups, the rates of neck pain are higher for those who had an anterior discectomy without fusion, or who had a non-union after an attempted fusion, than for those with a solid fusion.⁴⁰ The fusion has the theoretical disadvantage of increasing the rate of adjacent disc degeneration, but this fact has not been proven conclusively by long-term follow-up studies.

Most recent reports would suggest that approximately 75% of patients will have an excellent result (no cervical or arm pain, no activity restrictions, and no pain medication usage); 15% will have a good result (occasional neck or arm pain, intermittent activity modifications, and occasional non-narcotic pain medication usage); 8% will have a fair result (improved but incomplete neck or arm pain relief, mild restriction of activities, and intermittent need for physical therapies or narcotic pain medications); and 2% will experience treatment failure (no relief or worsening of pain, persistent major restriction of activity, chronic medication usage, or need for reoperation). The identifiable causes of failure include unsuccessful fusion, inadequate resection of disc or osteophyte with persistent stenosis of the cord or root, complications from the approach, or inappropriate choice of operative levels. Ill-defined causes for failure include unrealistic expectations on the patient's part, inappropriate surgical intervention, and limitations of current medical technology to discern painful degenerative disc conditions from those associated with the normal aging process. Future study is needed.

CONCLUSION

Appropriate operative treatment for cervical radiculopathy can be successful. Proper patient selection with confirmatory neuroradiological imaging are essential to the clinical decision-making process. Either an-

terior or posterior procedures are acceptable. The choice of approach is determined by consideration of the character of the disc herniation; the clinical presentation; and the surgeon's preference, training, and experience. The anterior approach can address central and herniations better than the posterior approach, but both are excellent techniques for lateral herniations. MM

Michael Smith is a spine surgeon with Minnesota Spine Center in Minneapolis.

REFERENCES

- Gibson MJ, Buckley J, Mawhinney R, Mulholland RC, Worthington BS. Magnetic resonance imaging and discography in the diagnosis of disc degeneration: a comparative study of 50 discs. *J Bone Joint Surg* 1986;72A:1171-7.
- Gore DR, Sepic SB. Anterior cervical fusion for degenerated or protruded discs: a review of one hundred forty-six patients. *Spine* 1984;9:667-71.
- Kondo K, Molgaard CA, Kurland LT, Onofrio BM. Protruded intervertebral cervical disc: incidence and affected cervical level in Rochester, Minnesota, 1950 through 1974. *Minn Med* 1981;64:751-3.
- Yu S, Sether LA, Ho PSP, Wagner M, Houghton VM. Tears of the annulus fibrosus: correlation between MR and pathologic findings in cadavers. *J Neuroradiol* 1988;9:367-70.
- Boden SD, McCowin PR, Davis DO, Dina TS, Mark AS, Wiesel S. Abnormal magnetic-resonance scans of the cervical spine in asymptomatic subjects: a prospective investigation. *J Bone Joint Surg* 1990;72A:1178-84.
- Hitselberger WF, Witten RM. Abnormal myelograms in asymptomatic patients. *J Neurosurg* 1968;28:204-6.
- Lee SH, Coleman PE, Hahn FJ. Magnetic resonance imaging of degenerative disc disease of the spine. *Radiol Clin North Am* 1988;26:949-64.
- Teresi LM, Lufkin RB, Reicher MA, et al. Asymptomatic degenerative disk disease and spondylosis of the cervical spine: MR imaging. *Radiol* 1987;164:83-8.
- Emery SE, Bohlman HH. Osteoarthritis of the cervical spine. In: RW Moskowitz, DS Howell, VM Goldberg, HJ Mankin, eds. *Osteoarthritis: diagnosis and medical/surgical management*. 2nd ed. Philadelphia: W.B. Saunders, 1992:651-68.
- Nurick S. The pathogenesis of the spinal cord disorder associated with the cervical spondylosis. *Brain* 1972;95:87.
- Whitecloud T. Complications of anterior cervical fusion. In: *Instructional course lectures*. Vol. XXVII. St. Louis: CV Mosby Company, 1978.
- Bohlman HH, Emery SE, Goodfellow DB, Jones PK. Robinson anterior cervical discectomy and arthrodesis for cervical radiculopathy. *J Bone Joint Surg* 1993;75A:1298-1307.
- Kellgren JH, Lawrence JS. Osteoarthritis and disk degeneration in an urban population. *Ann Rheum Dis* 1958;17:388-97.
- Williams JL, Allen MB Jr, Harkness JW. Late results of cervical discectomy and interbody fusion: some factors influencing the results. *J Bone Joint Surg* 1968;50A:277-86.
- Herkowitz HH. A comparison of anterior cervical fusion, cervical laminectomy, and cervical laminoplasty for the surgical management of multiple level spondylotic radiculopathy. *Spine* 1988;13:774-80.
- Modic MT, Masaryk TJ, Mulopulos GP, Bundschuh C, Han JS, Bohlman HH. Cervical radiculopathy: prospective evaluation with surface coil MR imaging, CT with metrizamide, and metrizamide myelography. *Radiol* 1986;161:753-9.
- DePalma AF, Rothman RH. *The intervertebral disc*. Philadelphia: W.B. Saunders, 1970:30-57.
- Herkowitz HH, Kurz LT, Overholt DP. Surgical management of cervical soft disc herniation: a comparison between the anterior and posterior approach. *Spine* 1990;15:1026-30.
- Bohlman HH. Cervical spondylosis with moderate to severe myelopathy: a report of seventeen cases treated by Robinson anterior cervical discectomy and fusion. *Spine* 1977;2:151-62.
- Crandall PH, Gregorius FK. Long-term follow-up of surgical treatment of cervical spondylotic myelopathy. *Spine* 1977;2:139-46.
- Connolly ES, Seymour RJ, Adams JE. Clinical evaluation of anterior cervical fusion for degenerative cervical disc disease. *J Neurosurg* 1965;23:431-7.
- Aronson N, Filtzer DL, Bagan M. Anterior cervical fusion by the Smith-Robinson approach. *J Neurosurg* 1968;29:397-414.
- Robinson RA, Smith GW. Anterolateral cervical disc removal and interbody fusion for cervical disc syndrome [Abstract]. *Bull Johns Hopkins Hosp* 1955;96:223-4.
- Robinson RA, Walker AE, Ferlic DC, Wiecking DK. The results of anterior interbody fusion for the cervical spine. *J Bone and Joint Surg* 1962;44A:1569-87.
- Aronson NI. The management of soft cervical disc protrusions using the Smith-Robinson approach. *Clin Neurosurg*

1973;20:253-8.

26. Brodsky A. Management of radiculopathy secondary to acute cervical disc degeneration and spondylosis by the posterior approach in the cervical spine. Philadelphia: JBLippincott Company, 1983: 395-402.

27. Bailey R, Bagley C. Stabilization of the cervical spine by anterior fusion. J Bone Joint Surg 1960;42A:565-94.

28. Cloward RB. The anterior approach for removal of ruptured cervical disks. J Neurosurg 1958;15:602.

29. DePalma AF, Rothman RH, Lewinnek GE, Canale ST. Anterior interbody fusion for severe cervical disc degeneration. Surg Gynecol Obstet 1972;134:755-8.

30. Riley LH Jr, Robinson RA, Johnson KA, Walker AE. The results of anterior interbody fusion of the cervical spine: review of ninety-three consecutive cases. J Neurosurg 1969;30:127-33.

31. Brodsky AE, Khalil MA, Newman BP. Comparison of posterior vs. anterior repair for pseudoarthrosis of anterior interbody fusions of cervical spine. Orthop Trans 1988;12:47.

32. Lindsey RW, Newhouse HE, Leach J, Murphy MJ. Nonunion following two-level anterior cervical discectomy and fusion. Clin Orthop 1987;223:155-63.

33. Rosenorn J, Hansen EB, Rosenorn MA. Anterior cervical discectomy with and without fusion. J Neurosurg 1983;59:252-5.

34. Hirsch C, Wickbom I, Lidstrom A, Rosengron K. Cervical disc resection. J Bone Joint Surg 1964;46A:1811-21.

35. Bernhardt T. Anterior microdiscectomy: a preliminary report on a prospective series. Presented at the Cervical Spine Research Society, New Orleans, Louisiana, 1990.

36. Smith MD, Bolesta MJ, Leventhal M, Bohlman HH. Postoperative cerebrospinal fluid fistula associated with erosion of the dura. J Bone Joint Surg 1992;74A:270-7.

37. Zeidman SE, Ducker TB. Posterior cervical laminoforaminotomy for radiculopathy: review of 172 cases. Neurosurgery 1993;33:356-62.

38. Kimura I, Oh-Hama M, Shingu H. Cervical myelopathy treated by canal-expansive laminoplasty. J Bone Joint Surg 1984;66A:914-20.

39. Lansford LD, Bissonette DJ, Jannetta PJ, Sheptak PE, Zorub DS. Anterior surgery for cervical disc disease, part 1: treatment of lateral cervical disc herniation in 253 cases. J Neurosurg 1980;53:1-11.

40. Farey ID, McAfee PC, Davis RF, Long DM. Pseudarthrosis of the cervical spine after anterior arthrodesis: treatment by posterior nerve-root decompression, stabilization, and arthrodesis. J Bone Joint Surg 1990;72A:1171-7.

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree™

Minneapolis 667-0705

©1995 Norwest Bank Minnesota N.A.
Member FDIC

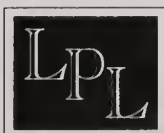
800 No-Load Mutual Funds

Professional Management Through Asset Allocation

One Consolidated Statement

No Commissions*

*If this sounds like a better way to invest, call today
and ask me about our SAM program.*



ADVISORY
SERVICES

Wayne E. Bernardo

2500 Foshay Tower
Minneapolis, MN 55402

(612) 337-8484

(800) 755-5877

*Investors in SAM pay a small annual fee based on
account value; nominal transaction costs occur.

LINSCD/PRIVATE LEDGER A REGISTERED INVESTMENT ADVISOR

Improvements in Diabetes Treatment

A Minnesota clinician and researcher comments on recent achievements in upgrading diabetes therapy.

Bruce R. Zimmerman, M.D.

When insulin therapy was introduced in the 1920s, health care providers thought it would effectively eliminate the problem of diabetes. Unfortunately, beginning in the 1930s, the chronic complications of diabetes were recognized, and their frequency has escalated since then. In 1992, medical care of people with diabetes cost about \$105 billion in the United States—three times the cost of medical care for those without the disease.¹ In Minnesota the direct and indirect costs associated with diabetes were estimated to be more than \$300 million in 1988.² In young people, end-stage renal disease is responsible for most of the cost, and in the elderly, cardiovascular disease is to blame. These figures do not reflect the burden of decreased quality and duration of life for people with diabetes.

Through the years, many studies have demonstrated an association between the chronic complications of diabetes and the degree of hyperglycemia.³ Studies in animals, including several done at the University of Minnesota, strongly suggested that improved glycemic control would decrease or even eliminate diabetes complications.⁴ It was not until the late 1970s that studies done at several centers, including the Mayo Clinic, demonstrated that the combination of self-monitoring blood glucose and following a complex insulin program could greatly improve blood glucose control in people with insulin-dependent diabetes mellitus (IDDM,

Type I).⁵ Introduction of glycosylated hemoglobin (glycated hemoglobin, HbA1c, HbA1) determinations allowed an objective, reproducible, inexpensive measure of the effectiveness of glucose control over time.

These factors encouraged the National Institutes of Health to initiate the Diabetes Control and Complications Trial (DCCT) in 1982. As reported in 1993, the DCCT conclusively demonstrated in people with IDDM that the development and progression of retinopathy, nephropathy, and neuropathy can be prevented with better glycemic control.⁶ Health professionals and people with diabetes in Minnesota contributed greatly to this remarkable study. The International Diabetes Center in Minneapolis, the Mayo Clinic, and the University of Minnesota participated as clinical centers and, in addition, the university served as the central laboratory. No other state had more than two participating centers.

In several respects, Minnesota has reason to be proud of its medical care systems for people with diabetes. For 15 years the Minnesota Department of Health has conducted a Diabetes Control Project with funding from the Centers for Disease Control and Prevention. This project has improved diabetes surveillance, developed quality control systems in cooperation with several primary care clinics, and initiated programs in minority populations. The department was recently one of two state health departments to successfully compete for enhanced

funding to extend the project. With part of its increased funding, the Health Department will develop recommendations for implementing the DCCT findings in Minnesota. Partially as a result of these efforts, a recent American Diabetes Association index ranked Minnesota first in diabetes care.

There is no room for complacency, however. A recent publication reviewed diabetes medical care by primary care physicians in Minnesota and Wisconsin and found the care to be far from optimum. Physicians indicated that acceptable blood glucose control is rarely achieved in their patients. Only about 4 percent of non-insulin-dependent (NIDDM, Type II) patients were estimated to have achieved their target HbA1c values.⁷ Other surveys have found an abysmal record for the frequency of what should be annual eye examinations, annual microalbuminuria determinations, and regular glycosylated hemoglobin determinations.⁸

In an attempt to improve the care of people with diabetes, the American Diabetes Association published "Standards of Medical Care for People with Diabetes Mellitus" in 1989 and updated the standards based on the DCCT results in 1994.⁹ The standards serve as a framework for care guidelines developed by groups such as the Institute for Clinical Systems Integration in Minnesota. There is concern that short-sighted third-party payers and managed care organizations will hinder

implementation of the standards if they evaluate expenses over the first few years only. Implementation of the standards definitely increases costs in the first years because they call for additional care. The major decrease in expenses will be achieved through reduced complications, but this won't occur for at least five years; however, appropriate care may quickly reduce the cost of emergency department visits and of unnecessary hospitalizations for initiation of insulin therapy, for treatment of diabetic ketoacidosis, and for foot complications. Through its advocacy efforts, the American Diabetes Association—Minnesota Affiliate was successful in requesting that the 1994 Minnesota Legislature mandate coverage for all physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, which will at least help patients follow the recommendations.

Following this article is an insert, "Upgrading Diabetes Therapy," that outlines the DCCT findings and the ADA standards of care and offers some practical suggestions for improving glycemic control in people with NIDDM. Several aspects of this insert provoke comment.

IDDM is characterized by profound insulin deficiency. Our inability to physiologically replace endogenous insulin with simple insulin injection programs results in a high degree of blood glucose instability in most people with IDDM. Less than 5 percent of people with IDDM can achieve adequate long-term blood glucose control on one or two insulin injections daily. Complex insulin programs that use three or more daily insulin injections or an insulin infusion pump are necessary to consistently achieve the degree of blood glucose control considered acceptable since the DCCT was completed. These insulin programs must be individualized, constantly monitored, and coupled with patient education and motivation. IDDM is relatively uncommon, and most primary care physicians will treat only a few IDDM patients in their practices. Therefore, it is unlikely they will have the experience and resources to properly

manage complex insulin programs. Because all people with IDDM should at least have the opportunity to consider such treatment, they should be referred to an experienced health care team for evaluation and co-management.¹⁰ Fortunately, Minnesota has a number of well-qualified medical centers experienced in intensive insulin treatment.

The situation with NIDDM is more complex. Do the DCCT findings apply to NIDDM? Scientifically, the answer is uncertain, but the pathologic similarity between the microvascular complications in IDDM and NIDDM makes it highly unlikely they have different etiologies. People with NIDDM should similarly experience reduced microvascular complications as a result of good glycemic control.¹¹ This is not a trivial achievement. About 60 percent of patients with end-stage renal disease in the United States have NIDDM. Nonetheless, the major cause of death in patients with NIDDM is coronary artery disease.

The DCCT was not expected to have the power to identify a difference in macrovascular disease between the treatment groups, because the participants were young and in good health except for their diabetes. The finding of a beneficial trend in favor of intensive treatment was a surprise. Good glycemic control improves several risks for macrovascular disease, such as the lipid profile, lipoprotein glycosylation and oxidation, and platelet adhesiveness. It is reasonable to assume that good control will reduce coronary artery disease, and the fear that insulin treatment will accelerate it is unsupported. To effectively reduce coronary artery disease in people with NIDDM, physicians should follow a treatment approach that attempts to reduce all modifiable risk factors for atherosclerosis.

The following insert outlines a stepped-care approach to improve glycemic control in patients with NIDDM, which in some ways oversimplifies the difficult choices physicians must make when treating these patients. Individualized goal setting is the first step in choosing a treatment plan. The "go-for-the-green"

goals are not appropriate for all patients because of other medical problems or advanced age. Not all patients should start treatment at step 1. At diagnosis, many patients with NIDDM will have symptoms or fasting blood glucose values >200 mg/dl. With symptoms and blood glucose >200 mg/dl, it is often appropriate to start a sulfonylurea immediately, and with the blood glucose >300 mg/dl, to start insulin injections. Prompt reduction of the blood glucose may improve insulin secretion and reduce insulin resistance by ameliorating what has been called glucotoxicity. These improvements and diet therapy may allow subsequent termination of the sulfonylurea or insulin injection therapy.

In this and similar stepped-care approaches, insulin therapy for NIDDM is always considered the final step. If insulin therapy is used relatively early, when endogenous insulin secretion has not deteriorated too much, simple insulin programs using modest doses may be very effective. Insulin therapy must be individualized and should not be made more complex unless treatment goals are not achieved.¹² A variety of insulin programs can be used. Morning or evening intermediate or long-acting insulin, intermediate and regular insulin mixed by the patient and taken once or twice daily, or premixed insulin once or twice daily can be used.¹³ The appropriateness of the program is judged by the results, not some arbitrary guideline.

The steps outlined in the insert do not include metformin at any point, since this drug was not available in the United States at the time of writing. Metformin has been used around the world for many years to treat NIDDM, and the FDA recently approved its use in the United States. Available evidence suggests metformin will benefit some patients who fail sulfonylurea therapy when it is used either alone or in combination with a sulfonylurea. Metformin may be particularly helpful in the obese patient.¹⁴ The final decision regarding the role of metformin in a stepped-care approach will require additional experience with its use in the United States.

The future is encouraging for

people with diabetes. The DCCT shows we can reduce the risk of complications by at least 50 percent, and the American Diabetes Association has provided guidelines to assist us in improving the care of people with diabetes. The challenge for clinicians is to implement these lessons; the challenge for researchers is to develop new treatments that will make the goal of good glycemic control easier for patients. MM

Bruce Zimmerman is an associate professor of internal medicine and endocrinology at the Mayo Graduate School of Medicine in Rochester, Minnesota. He received an honorarium from Novo Nordisk Pharmaceuticals Inc. for writing this article.

REFERENCES

1. Rubin RJ, Altman WM, Mendelson DN. Health care expenditures for people with diabetes mellitus, 1992. *J Clin Endocrinol Metab* 1994;78:809A-F.
2. Roesler J, Crozier KM, Bishop D. The impact of diabetes in Minnesota, 1988. *Minn Med* 1991;74(2):25-9.
3. Zimmerman BR. Influence of the degree of control of diabetes on the prevention, postponement, and amelioration of late complications. *Drugs* 1989;38:941-56.
4. Mauer SM, Sutherland DER, Steffes MW, et al. Pancreatic islet transplantation: effects on the glomerular lesions of experimental diabetes in the rat. *Diabetes* 1974;23:748-53.
5. Rizza RA, Gerich JE, Haymond MW, et al. Control of blood sugar in insulin-dependent diabetes: comparison of an artificial endocrine pancreas, continuous subcutaneous insulin infusion, and intensified conventional insulin therapy. *N Engl J Med* 1980;303:1313-8.
6. The Diabetes Control and Complications Trial Research Group. The effect of intensive insulin treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993;329:977-86.
7. Peterson KA. Diabetes care by primary care physicians in Minnesota and Wisconsin. *J Fam Pract* 1994;38:361-7.
8. Marrero DG. Current effectiveness of diabetes health care in the U.S.: how far from the ideal? *Diabetes Reviews* 1994;2:292-8.
9. American Diabetes Association. Clinical practice recommendations: standards of medical care for patients with diabetes mellitus. *Diabetes Care* 1993;16 (Suppl 2).
10. Zimmerman BR. Glycemic control in diabetes mellitus: toward the normal profile?

Drugs 1994;47:611.

11. Pollet RJ, El-Kebbi IM. The applicability and implications of the DCCT to NIDDM. *Diabetes Reviews* 1994;2:413-27.

12. Zimmerman BR, Service FJ. Management of non-insulin dependent diabetes mellitus. *Med Clin North Am* 1988;72:1355-64.

13. Nathan DM, Roussel A, Godine JE. Glyburide or insulin for metabolic control in non-insulin dependent diabetes mellitus. *Ann Intern Med* 1988;108:334-40.

14. Campbell IW. Management of type-2 diabetes mellitus with special reference to metformin therapy. *Diabetes Metab* 1991;17:191-6.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
612-885-6224
1-800-842-6469





Joslin
Diabetes
Center

Novo Nordisk

DIABETES

Care

Upgrading Diabetes Therapy

Now that we know it matters



What every primary care physician needs to know

Novo Nordisk
Pharmaceuticals Inc.
The worldwide leader
in diabetes care

Developed in
collaboration with the
Joslin Diabetes Center

ADVISORY PANEL**Richard S. Beaser, MD**

MEDICAL DIRECTOR, DIABETES TREATMENT UNIT, JOSLIN DIABETES CENTER

Rex S. Clements, MD

VICE PRESIDENT AND MEDICAL DIRECTOR, NOVO NORDISK PHARMACEUTICALS INC.

Susan Crowell, BSN, RN, CDE

JOSLIN DIABETES CENTER

Emmy Friedlander, RD, MS, CDE

JOSLIN DIABETES CENTER

Edward S. Horton, MD

MEDICAL DIRECTOR, JOSLIN DIABETES CENTER; PROFESSOR OF MEDICINE,
HARVARD MEDICAL SCHOOL

Alan M. Jacobson, MD

HEAD, MENTAL HEALTH SECTION AND ASSOCIATE PROFESSOR OF PSYCHIATRY,
HARVARD MEDICAL SCHOOL

Roberta L. Schneider, MD, FACEP

VICE PRESIDENT MEDICAL AND PROFESSIONAL AFFAIRS,
NOVO NORDISK PHARMACEUTICALS INC.

Donald C. Simonson, MD

HEAD, SECTION OF CLINICAL PHYSIOLOGY AND ASSOCIATE PROFESSOR OF
MEDICINE, HARVARD MEDICAL SCHOOL

Joseph I. Wolfsdorf, MD

CHIEF, PEDIATRICS, JOSLIN DIABETES CENTER; ASSOCIATE PROFESSOR OF
PEDIATRICS, HARVARD MEDICAL SCHOOL

Views expressed in this publication are those of the advisory panel. This publication was not endorsed by or produced in affiliation with the Diabetes Control and Complications Trial.

All changes in insulin or other diabetes medications should be made cautiously and only under medical supervision.

All rights reserved. No part of this program may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, electrostatic, magnetic tape, mechanical, photocopying, recording, or otherwise without permission from Novo Nordisk Pharmaceuticals Inc.

Novo Diabetes CareTM and Novolin[®] are trademarks of Novo Nordisk A/S.

Copyright © 1994 Novo Nordisk Pharmaceuticals Inc.

THE DEBATE IS OVER

In the spring of 1993, researchers called an early halt to the Diabetes Control and Complications Trial, or DCCT. Launched in the early 1980s, this multicenter study was designed to resolve, once and for all, whether “tight” blood glucose control can help prevent or slow the progression of long-term complications of diabetes, including eye, nerve, and kidney disease. The answer, in short, is yes.¹

THE DCCT DESIGN

In the DCCT, 1,441 volunteers with type 1 (insulin-dependent) diabetes, ages 13–39, were randomized to one of two diabetes management plans:

- “conventional” therapy, with one or two injections per day, once-daily monitoring of blood or urine glucose, dietary education, and four physician visits a year;
- “intensive” therapy, involving three or more injections per day, or use of an insulin pump, with dosages adjusted on the basis of four or more daily blood glucose

tests; intensive diabetes education and dietary, exercise, and psychosocial counseling; and monthly physician visits.

Basic clinical goals

For conventional therapy: “Clinical well-being”—no symptoms of high or low blood sugar; normal growth and development.

For intensive therapy: Blood glucose levels as close to normal as possible.

WHAT THE STUDY SHOWED

Benefits of intensified control

Both groups were monitored for signs of eye, nerve, or kidney disease. Overall, the intensive therapy group experienced a profound reduction in long-term complications.

Intensive therapy reduced

- retinopathy by up to 76%;
- nephropathy by up to 56%;
- neuropathy by up to 60%.

Overall, the intensive therapy group experienced a profound reduction in long-term complications.

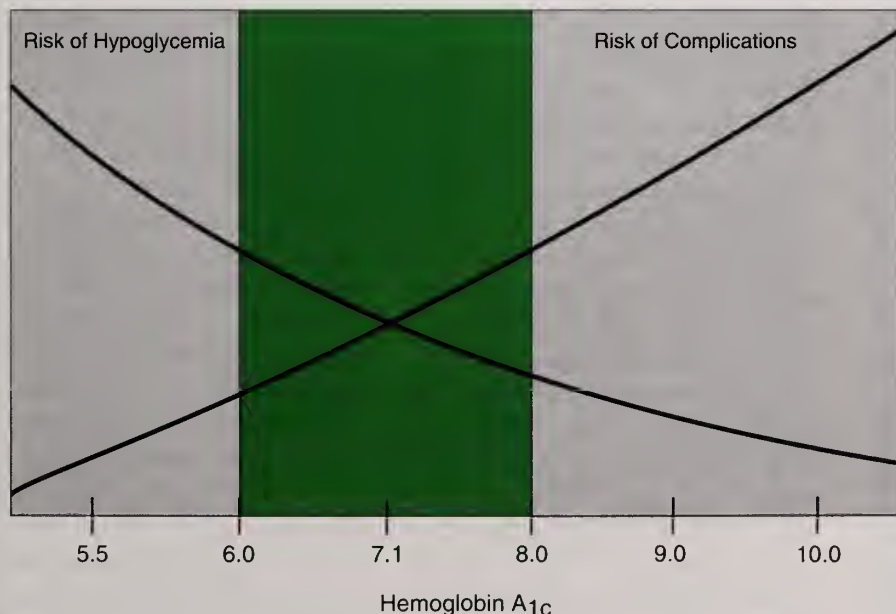


Figure. Artist's conception of principal DCCT findings. Based on results reported in *N Engl J Med* 1993;329:977-986.

The lower the average glycosylated hemoglobin levels (see Figure), the lower the risk for long-term complications.

Risks of intensified control

Despite frequent self-monitoring of blood glucose (SMBG) and close contact with the healthcare team, the intensively treated patients had *three times* as many severe hypoglycemic episodes (those requiring assistance from someone else or emergency room visits) as the conventionally treated patients.

Intensive treatment also promoted weight gain: After five years, intensively treated patients had gained approximately 10 pounds more than conventionally treated patients over the same period.

WHAT THE FINDINGS MEAN TO YOU

The goals you and your patients set today for glycemic control can influence your patients' future health substantially.

DOES THIS APPLY TO ALL PATIENTS?

The DCCT subjects all had insulin-dependent diabetes mellitus (IDDM), also called type I or (formerly) "juvenile-onset" diabetes. This disorder completely destroys a person's insulin-making capacity; insulin therapy is needed for survival. Roughly 300,000 people in the United States have this form of diabetes, which usually develops in youth or early adulthood.

The great majority of people with diabetes have a more common form of the disorder, known as non-insulin-dependent diabetes mellitus (NIDDM), also called type II or (formerly) "maturity-onset" diabetes. This disease usually strikes people who are older than 40 and overweight. Some

6.5 million Americans are known to have NIDDM, and it's estimated that another 6–7 million cases remain undiagnosed.

Although the DCCT findings directly apply only to patients with IDDM, the American Diabetes Association (ADA) has stated that

it seems reasonable to recommend tight control in many patients with non-insulin-dependent disease because it is presumed that the mechanisms by which glucose causes complications is the same in both forms of diabetes.²

Although it can persist for years with few or no symptoms, NIDDM is not a "mild" form of diabetes. It also carries a great risk for chronic complications.

WHAT ABOUT OTHER COMPLICATIONS OF DIABETES?

People with diabetes are at increased risk for atherosclerosis—and thus for coronary disease, stroke, and peripheral vascular disease. These complications appear to be less tightly tied to glycemia than eye, nerve, and kidney complications; serum cholesterol and lipids, blood pressure, and smoking history also contribute to macrovascular complications.

Despite the confounding effects introduced by multiple risk factors, the group under intensive diabetes management had fewer coronary and peripheral vascular events than the controls. When all cardiovascular and peripheral vascular events were combined, intensive therapy reduced the risk of macrovascular disease by 41%. When the study ended, this trend was approaching, but had not yet reached, statistical significance. The ADA noted, "[It] is reasonable to suppose

The goals you and your patients set *today* for glycemic control can influence your patients' *future* health *substantially*.

that better [glycemic] control might slow macrovascular in addition to microvascular complications.”²

HOW INTENSE DOES “INTENSIVE” HAVE TO BE?

What are the magic glucose numbers? Strictly speaking, there are none. The DCCT proved that the risk of long-term complications is lower in people with IDDM who had more ambitious glucose targets than in those with less ambitious targets. The trial wasn’t designed to compare risks at specific levels of *actually achieved* control.

That’s not to say that the goals weren’t specific. The targets of intensive therapy were

- fasting and premeal blood glucose levels 70–120 mg/dL;
- postprandial glucose <180 mg/dL;
- 3:00 a.m. blood glucose (monitored weekly) >65 mg/dL;
- glycosylated hemoglobin (HbA_{1c}) levels as close to normal as possible (“normal” being ≤6.05% in the assay used by the DCCT).

When the DCCT investigators analyzed the findings by plotting average glycosylated hemoglobin levels against the risk of sustained retinopathy progression, the relation proved remarkably straightforward: The lower the mean glycosylated hemoglobin levels, the lower the risk for retinopathy. That result strongly suggests that *any* improvement in blood glucose control is likely to lower the risk of complications to some degree.

MEETING THE STANDARDS OF CARE

The American Diabetes Association has published standards of care for people with diabetes.³ *If you treat diabetes, you should document your*

adherence to these standards, regardless of the specific glycemic targets you and your patients set. A sample checklist of these recommendations appears on page 13.

UPGRADING DIABETES THERAPY

IDDM: BASIC GUIDELINES

The management of diabetes with intensive insulin regimens requires substantial resources and expertise. If your practice is not geared for this kind of treatment approach, it may be preferable to refer IDDM patients to an endocrinologist or diabetes center. At a minimum:

- Every patient with IDDM should take at least two insulin injections a day. If they are taking only two, these should contain a mixture of short- and intermediate-acting insulin. Such a regimen may achieve adequate glycemic control in individuals who eat and exercise on very regular schedules. **However, three or more injections a day or use of an insulin pump should be recommended, unless clearly contraindicated.**
- Every patient with IDDM (or parent of young children with IDDM) should measure blood glucose at least before each injection. They should be taught how to adjust premeal dosages of short-acting insulin on the basis of SMBG results, calorie intake, and physical activity.
- *No patient with IDDM should adjust insulin on the basis of urine glucose tests alone.* Urine tests for ketones, however, should be performed during

TOOLS FOR INTENSIFYING CONTROL

Why has the 50-year debate over blood glucose control and long-term complications been resolved only now? Because the tools for attempting truly tight control have only been in existence since the late 1970s. The key advances, in addition to new drugs and insulin-delivery systems, were two new ways to monitor the effects of diabetes therapy:

- **Self-monitoring of blood glucose (SMBG).** Finger-prick blood glucose tests enable patients to determine their blood glucose level immediately, anywhere. For patients on advanced insulin regimens, SMBG allows precise premeal dosage adjustments. For anyone with diabetes, it can help monitor the effectiveness of treatment and serve as a motivational tool.

- **Glycosylated hemoglobin testing** (also known as glycohemoglobin, glycated hemoglobin, HbA_{1c}, or HbA_{1c} testing). This laboratory test measures the level of glucose-altered (glycosylated) hemoglobin that has accumulated in the blood over the preceding 2–3 months. It’s an indispensable gauge of a person’s overall level of diabetes control. (**Note:** Different laboratories use slightly different scales for their glycosylated hemoglobin results—blood from a normal volunteer might read 6% at one lab and 7% at another. So know the reference values for the lab you use.)

Patients with IDDM should be taught how to adjust premeal dosages of short-acting insulin on the basis of blood glucose test results, calorie intake, and physical activity.

periods of illness or stress, or whenever blood glucose rises above 240 mg/dL.

- Every patient with IDDM should carry some form of simple carbohydrate (eg, glucose tablets) to counteract hypoglycemia. Family members (and, ideally, co-workers or school personnel) should know how to administer glucagon in the event of severe hypoglycemia.
- Every patient with IDDM should have 24-hour access to a health professional knowledgeable about diabetes.
- Every patient with IDDM should receive education from professionals who can help develop and monitor a diabetes management program; this should include an eating plan, exercise plan, and training on such topics as managing diabetes during sick days and when traveling.

According to the DCCT researchers, IDDM patients for whom intensive diabetes therapy *may not* be appropriate include

- patients who experience frequent severe hypoglycemia or who do not experience the typical early warning signs of hypoglycemia (eg, sweating, trembling);
- patients whose diabetic complications, particularly renal disease, are already far advanced;
- patients with coronary or cerebrovascular disease (whose conditions may be worsened by frequent or severe hypoglycemia);
- children under 13 years. (The DCCT didn't study anyone younger. According to the ADA, tight control is contraindicated in children under 2 years, and should be attempted with extreme caution in those under 7 years.)²

NIDDM: A Stepped-Care Approach

The chart running across the centerfold is a simplified guideline for upgrading diabetes therapy in people with NIDDM. It is generalized and does not apply to all patients and situations. The glucose values defining "unacceptable," "better," and "best" are broad estimates, based on typical blood glucose tests. The accompanying glycosylated hemoglobin values are a somewhat more reliable guide.

Key points

- *Resource inventory.* Before intensifying a patient's therapy—indeed, before treating diabetes at all—you should take stock of the resources and knowledge needed to apply the regimen successfully. If they are not available, it may be preferable to refer the patient to a specialist or diabetes treatment program. Resource needs grow cumulatively with more advanced diabetes treatment regimens.
- *Go for the green.* The object is to improve blood glucose control from the red "unacceptable" zone (BG >200 mg/dL; HbA_{1c} >10%) to the green "best" zone (BG <140 mg/dL; HbA_{1c} 6–8%), where the best chances of preventing complications reside.
- *The middle ground.* The yellow ("better") zone corresponds roughly to conventional control in the DCCT. At this level of control, a patient will likely feel well most of the time. But the risk of complications is significantly higher than that for patients in the "best" zone.
- *Document discussions.* There may be sound reasons why you

and your patient decide that “better” is good enough. But in light of the DCCT, make sure your patient understands that lower blood glucose levels will likely decrease the risk of complications, and document that discussion. Patients who develop complications in the future will have reason to ask whether their doctors took aggressive enough steps to move them from “better” to “best.” You should also advise the patient of the increased risk of hypoglycemia if a decision is made to intensify therapy.

STEP 1: DIET AND EXERCISE

Resource inventory

- Education capability for meal planning, exercise counseling, and (if required) weight loss
- Diabetes education capability (nurse/educator if possible)
- Minimum testing:
 - Glycosylated hemoglobin
 - Lipid profile
 - Microalbuminuria, serum creatinine
 - ECG, BP

For an individual newly diagnosed with NIDDM and without acute symptoms of diabetes, the first-line therapy is a diet and (if not medically contraindicated) exercise plan. In some patients, these measures may be all that's needed to control diabetes adequately, although about 85% of NIDDM patients do eventually require medication. Even then, diet remains essential. In fact, dietary backsliding is at the root of many medication “failures.”

Dietary goals. For obese NIDDM

patients—the majority—the primary dietary goal is weight loss. When patients lose weight, their tissues become more sensitive to insulin and thus remove more glucose from the blood; weight loss also reduces glucose production in the liver.

In addition to calorie restriction, dietary goals include

- distributing calories as evenly as possible throughout the day, to avoid large after-meal glucose “excursions”;
- maintaining a balanced diet, with about 50–60% of calories from carbohydrates (especially high-fiber foods), no more than 30% of calories from fat, and the balance from protein. In other words, a basic “heart healthy” diet;
- moderation in sugar and alcohol consumption. For most patients, strict prohibition of either is no longer considered necessary. Sugar taken as part of a balanced meal should not raise blood glucose dramatically.

If you have the expertise and the time, you can sit down with the patient, explain how food affects diabetes control, and help him or her develop a sensible and palatable meal plan. But weight loss is difficult, and you will probably need to enlist the aid of a registered dietitian or refer your patient to a local, reputable weight-loss program.

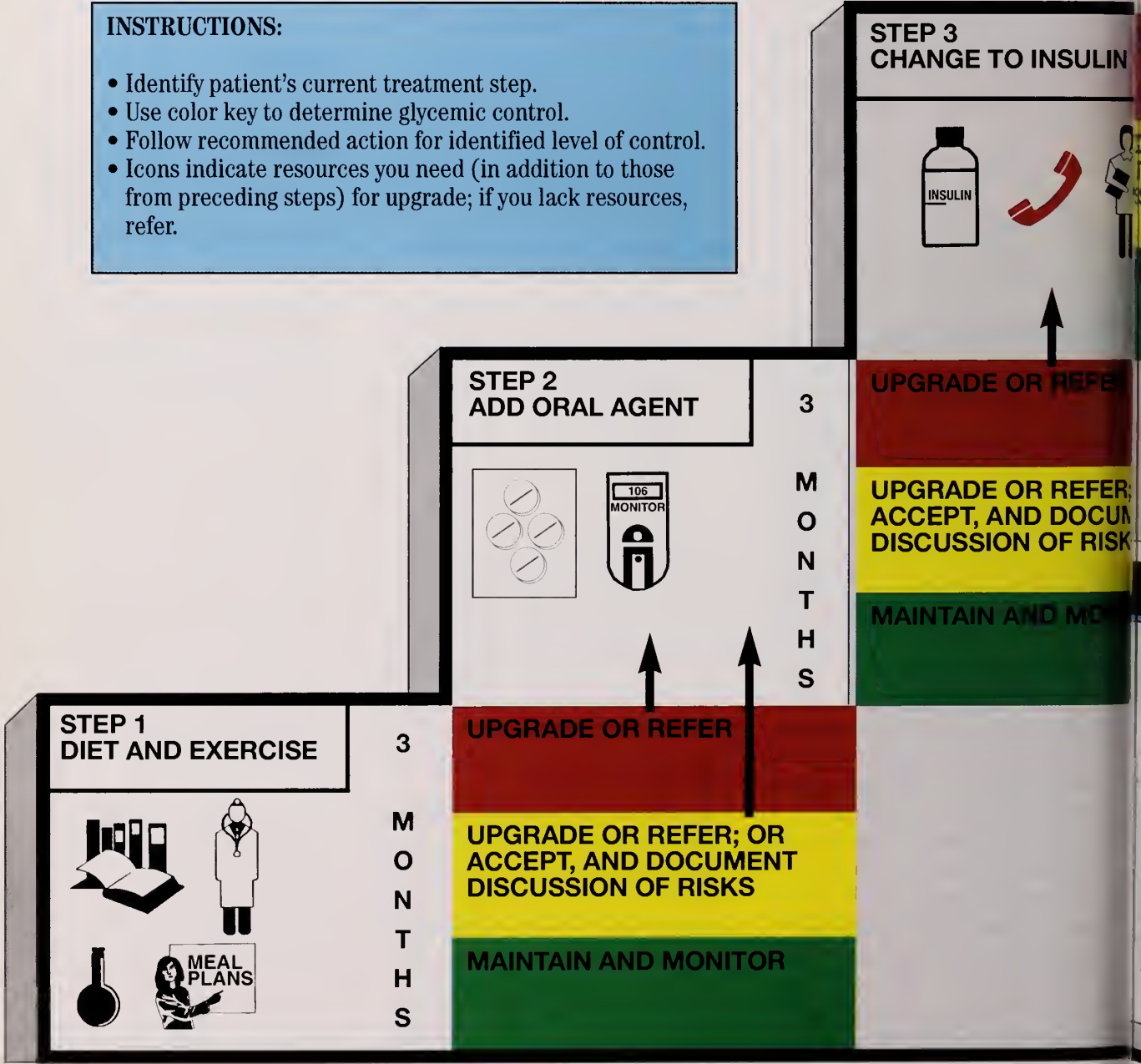
Exercise. Physical activity (specifically, aerobic exercise, as opposed to resistance training) lowers blood sugar acutely. Aerobic conditioning also increases the body's overall sensitivity to its own insulin, aids weight loss, and has a favorable impact on serum lipids. If a patient is new to exercise and over age 35, an exercise tolerance test is recommended to make sure

About 85% of NIDDM patients eventually require medication. Even then, diet remains essential.

UPGRADING GLYCEMIC CONTROL IN NIDDM: A STEPPED-CARE APPROACH

INSTRUCTIONS:

- Identify patient's current treatment step.
- Use color key to determine glycemic control.
- Follow recommended action for identified level of control.
- Icons indicate resources you need (in addition to those from preceding steps) for upgrade; if you lack resources, refer.



SAVE INSULIN
KEY



24
hours



DE OR REFER
DE OR REFER; OR AND DOCUMENT DISCUSSION OF RISKS
AND MONITOR

3
M
O
N
T
H
S

REFER!
REFER; OR ACCEPT, AND DOCUMENT DISCUSSION OF RISKS
MAINTAIN AND MONITOR

COLOR KEY

UNACCEPTABLE BG >200 mg/dL; HbA _{1c} >10%
BETTER BG 140–200 mg/dL; HbA _{1c} 8–10%
BEST BG <140 mg/dL; HbA _{1c} 6–8%

RESOURCE KEY

 Physician	 Lab tests	 Oral hypoglycemic agents
 Nurse/educator	 Dietitian	 Insulin
 Diabetes education	 Blood-glucose monitoring	 Hotline access
		 Psychological counseling

Glycosylated hemoglobin testing should be performed at least twice a year in all people with diabetes.

there is no underlying vascular disease. If an examination yields no reason to avoid exercise, recommend it. If the patient has no idea how to begin, you can have phone numbers of local exercise programs ready or suggest a trip to an exercise physiologist for help in developing a personalized program. If the patient has significant vascular disease, an exercise program should not be recommended until an appropriate medical evaluation has been completed.

Monitoring. If you treat diabetes, you must become familiar with glycosylated hemoglobin testing. When you are instituting or changing therapy, a baseline glycosylated hemoglobin test, followed by another in a few months, is an excellent way to see whether the patient's glycemic control has actually improved. This laboratory test should be performed *at least twice a year in all people with diabetes*, according to standards of diabetes care developed by the American Diabetes Association.³

If diet and exercise alone achieve acceptable control, glycosylated hemoglobin testing during periodic check-ups may be all the glucose monitoring needed. However, all patients should be encouraged to learn SMBG and use it regularly to determine how their treatment plan is working.

Monitoring for complications. Monitoring your patient for signs of long-term complications is also essential from the very start. Because NIDDM often goes undiagnosed for years, it's not unusual to discover signs of complications at the time diabetes is diagnosed. One fairly new resource in this regard is microalbuminuria testing—a way of detecting minute quantities of urinary protein. Even if a standard urine dipstick test turns up negative for protein, microalbuminuria could indicate early signs of diabetic kidney disease, a strong argu-

ment for intensive glucose control. Vigorous control of hypertension, if present, has also been shown to help slow the progression of nephropathy. Also, all people with diabetes who are older than 30 years or have had diabetes for at least 5 years should have yearly ophthalmic exams.

STEP 2: ADD ORAL HYPOGLYCEMIC AGENT

Resource inventory

- Resources as for Step 1
- Oral agent selection rationales
- Education on dosage, timing, adverse drug interactions, and hypoglycemia
- SMBG training

If, after a 3-month trial of diet and exercise, the regimen does not bring blood glucose concentrations into an acceptable range, or if it achieves "better" control when "best" is the agreed-upon goal, adding an oral hypoglycemic agent (OHA) is usually the next step. Like all clinical judgments, this is not an ironclad rule. Many physicians would consider insulin the first-line drug in some patients, eg, young, lean individuals with NIDDM.

A common side effect of sulfonylureas is hypoglycemia. Because research and clinical experience show that many patients cannot sense hypoglycemia correctly—and may treat for it when their blood glucose levels are in a normal range—those on OHAs also need to be trained in SMBG. SMBG can help document the effectiveness of treatment, confirm hypoglycemic episodes, and aid in recognition of high blood glucose levels caused by mistaken or excessive treatment for hypoglycemia.

Neither doctor nor patient should be lulled into thinking that an OHA, or insulin for that matter, is a license to abandon diet and exercise.

STEP 3: CHANGE TO INSULIN

Resource inventory

- Resources as for Steps 1 and 2
- Nurse/educator availability for education on insulin dosage, timing, injection techniques, hyper- and hypoglycemia
- Dietitian availability for coordinating meal plan with insulin injections.
- HbA_{1c} testing 2–4 times a year
- Physician accessibility during dosage adjustment periods

If OHAs at the maximum recommended dosage do not bring blood glucose concentrations out of the unacceptable range within 3 months, if they achieve “better” control when you and your patient have agreed your goal is “best,” or if they work for a time and then lose their effectiveness, the next step is insulin. Within the first year of use, OHAs prove insufficient in about 30% of patients; they lose effectiveness in 5 to 10% of users each year after that.

The framework of these simplified guidelines incorporates four sequential steps: 1) diet and exercise, 2) addition of OHAs, 3) change to insulin, and 4) intensive insulin therapy. In some cases, physicians have found that they could achieve more normal blood glucose concentrations and extend the period of OHA use by adding an injection of intermediate-acting insulin at bedtime.

Note that NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes

an insulin-requiring person with non–insulin-dependent diabetes.

In NIDDM, unlike IDDM, a regimen of two daily insulin injections stands a reasonable chance of achieving adequate—in some patients even excellent—glycemic control. Such success is most likely when NIDDM is of recent onset with relatively mild hyperglycemia.

A reasonable initial dose of insulin is 0.25 units per pound of body weight per day. Common two-injection insulin regimens, in order of increasing complexity, include

- Two injections of intermediate-acting insulin, two-thirds before breakfast and one-third before supper;
- Two injections of premixed insulin (eg, 70% NPH, 30% regular), two-thirds before breakfast and one-third before supper;
- Two injections of mixed short- and intermediate-acting insulin, where the dosage of the short-acting insulin is adjusted according to premeal SMBG test results and the anticipated size of the meal.

STEP 4: INTENSIVE INSULIN THERAPY

Resource inventory

- Resources as for Steps 1–3
- 24-hr hotline
- SMBG ≥ 4 times daily
- Nurse/educator availability for intensive training on hypoglycemia (awareness, prevention, treatment) and for advanced insulin dosage adjustment training
- Availability of professional help for emotional and motivational counseling

NIDDM does not become IDDM just because a patient switches to insulin. The patient simply becomes an insulin-requiring person with non–insulin-dependent diabetes.

If two injections per day, even in a split/mixed regimen, do not bring blood glucose concentrations into an acceptable range, or if they achieve "better" when you want "best," the last option is multiple-injection or insulin pump therapy: the "intensive" regimens used in the DCCT. These are not common regimens for treating NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance. They require experienced and available health professionals, and a dedicated, motivated patient.

Typical multiple-injection regimens include

- Three SMBG-adjusted premeal injections of regular insulin, with intermediate-acting insulin mixed in at supper, to cover glycemia overnight;
- Three-injection regimen consisting of 1) a prebreakfast injection of intermediate- and short-acting insulin, 2) a presupper injection of short-acting insulin, and 3) a bedtime injection of intermediate-acting insulin to last all night;
- Three SMBG-adjusted premeal injections of regular insulin plus an injection of long- or intermediate-acting insulin at bedtime.

Insulin pumps, preferred by some patients, are computerized, motor-

driven syringes that deliver insulin to a subcutaneous catheter. The pump, which contains short-acting insulin only, delivers a small amount constantly (the basal delivery) and allows the patient to adjust premeal doses (boluses) on the basis of SMBG results.

Unless you are already part of a team that includes, at a minimum, a diabetes nurse/educator, dietitian, and mental health professional, and unless a knowledgeable team member is available to answer questions 24 hours a day, it's best to leave these intensive regimens to diabetes specialists.

REFERENCES

1. The Diabetes Control and Complications Trial Research Group. The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. *N Engl J Med* 1993;329:977-986.
2. American Diabetes Association. Position statement: implications of the Diabetes Control and Complications Trial. *Diabetes Spectrum* 1993;6:225-227.
3. American Diabetes Association. Clinical practice recommendations. Standards of medical care for patients with diabetes mellitus. *Diabetes Care* 1993;16(Supp 2):10.

Intensive insulin regimens are not common therapy for NIDDM but may be necessary in patients who develop severe insulin deficiency in addition to insulin resistance.

PATIENT NAME _____

CLINICAL PRACTICE RECOMMENDATIONS FOR DIABETES MELLITUS

This guideline indicates minimum standards of continuing care for stabilizing patients with diabetes; it is not intended to preclude more extensive evaluation and management. A comprehensive medical history should be taken at the initial visit to confirm the diagnosis, review previous treatment, evaluate glycemic control and complications status, and provide a basis for continuing care. Any abnormal findings on physical examination should be re-evaluated at subsequent visits.

Indicate that a task was performed by initialing box. Shaded boxes are optional tasks.

VISIT	Initial	3 mo.	6 mo.	9 mo.	Annual	3 mo.	6 mo.	9 mo.	Annual
DATE									
PHYSICAL:									
Complete history and physical, including height									
Weight									
Blood pressure									
Ophthalmoscopic exam									
Foot exam									
Interim history and physical									
LABORATORY:									
HbA _{1c}									
Fasting plasma glucose		*	*	*		*	*	*	
Lipid profile									
Urinalysis ✓†									
Urinary microalbumin									
Serum creatinine									
ECG†									
OTHER:									

DOCUMENT GOALS AND MANAGEMENT PLAN									
REFERRAL TO OPHTHALMOLOGIST									

Adapted from *Diabetes Care*, 1994;17(6):616.

ICD-9 CODES:

- 250.____0 NIDDM, not stated as uncontrolled
 250.____2 NIDDM, uncontrolled
 250.____1 IDDM, not stated as uncontrolled
 250.____3 NIDDM, uncontrolled
 250.____ Indicates complication and type of diabetes

* may be useful

✓ annual retest recommended if abnormal

† many clinicians routinely test annually

**Novo Nordisk
Pharmaceuticals Inc.**

Printed in USA

Good News About Your Diabetes

Scientists have just proved that controlling blood sugar *carefully* can help prevent the long-term complications of diabetes.

A study called the Diabetes Control and Complications Trial (DCCT) compared two groups of people with diabetes:

- Those who controlled their blood sugar well enough to avoid extremes of high and low blood sugar and to feel well most of the time.
- Those who worked closely with doctors, nurses, and others to keep their blood sugar as near to normal as possible.

IT REALLY WORKED!

The extra effort paid off! People who worked harder to keep the amount of sugar in their blood near normal had fewer signs of diabetic eye, kidney, and nerve disease at the end of the 6 1/2-year study. These long-term problems were reduced by more than half. Keeping blood sugar as close to normal as possible also tended to lower the risk of heart disease and poor leg circulation.

WHO CAN BE HELPED?

The study was done only in people taking insulin, but experts agree that all people with diabetes—whether they're treated with diet or pills or insulin—can lower their risk of complications by improving their blood sugar control.

THE TRADE-OFF

But when you aim for normal blood sugar levels, you increase the chances of overshooting the target and lowering sugar levels too far. This is true mainly if you take insulin, but it can also occur if you take diabetes pills. In the DCCT, the group working toward normal blood sugar had three times more low blood sugar reactions than the other group. You can learn to watch out for these reactions and prevent or correct them, but they can be dangerous if not treated quickly and properly.

One other downside: if you take insulin several times a day, controlling blood sugar more tightly can cause some weight gain because insulin helps your body store calories better.

WHAT TO DO?

Ask your doctor about the DCCT and whether a change in treatment makes sense for you. Changing your treatment plan today could make a big difference to your health in the future.

WHAT ELSE IS NEW?

Diabetes experts recently spelled out the basic steps that all health professionals should follow for people with diabetes.

Whenever you visit your doctor or clinic, expect to discuss:

- how well your treatment plan is working
- the target glucose levels you're aiming for
- your blood glucose self-monitoring results
- any high or low blood glucose results
- your medications
- any changes in your routine

And you should have these checked:

- your weight
- your blood pressure
- your blood glucose
- your feet and eyes

You should also have a *glycosylated hemoglobin* test: it provides a snapshot of how well your blood glucose was controlled over the last 2–3 months.

BETWEEN VISITS

Write down your test results and make notes about things you want to talk about.

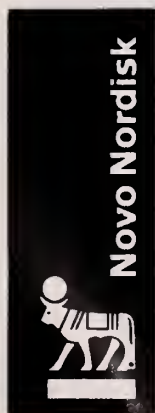
EVERY YEAR

You should have these tests:

- cholesterol
- triglycerides
- an electrocardiogram (heart test)
- kidney function
 - creatinine in blood
 - protein in urine
- a complete eye exam by an eye doctor

ASK QUESTIONS

And remember: the most important person on your healthcare team is **you!!**



Novo Nordisk Pharmaceuticals Inc.

The worldwide leader in diabetes care

For additional information call 1-800-727-6500

© 1994 Novo Nordisk Pharmaceuticals Inc. 054-93 Printed in U.S.A.

Experience a heartfelt evening

at
the American Heart Association's

Heart Gala

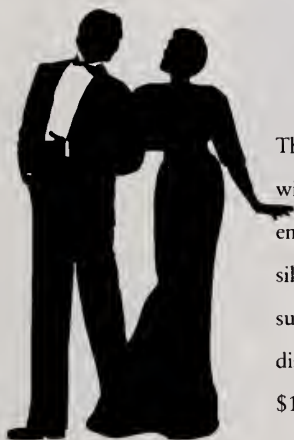
"With A Song in Your Heart"

April 29, 1995

Radisson Plaza Hotel

Minneapolis

This elegant, black-tie evening will include dining, dancing, entertainment, and live and silent auctions. Proceeds will support the fight against heart disease and stroke. Tickets are \$100. For info, call 897-8343.



STUTZMAN-HELLING COMPANY

Your Business & Tax Allysm

CONSULTANTS, ACCOUNTING AND TAX ADVISORS
APPRAISALS ARE OUR SPECIALTY
612-546-6375

K



Make plans to be at C.F. Anderson's Casino & Product Fair

April 13, 1994

Thunderbird Motel, Bloomington

- | | |
|---------------|-------------|
| ♥ Roulette | ♦ Auction |
| ♠ Blackjack | ♣ Good food |
| ♣ Dice games | ♠ Seminars |
| ♦ Door prizes | ♥ Exhibits |

Watch for your invite!

You are always
a winner!



URGENT CARE DEPARTMENT

- BC/BE Family Practitioners, General Internists, or Emergency Medicine Practitioners
- Three positions available; nine positions filled
- Varied and challenging patient population
- New flexible scheduling options, all considered full time with same base pay:
 - #1 40 hrs/wk, no evenings/no weekends
 - #2 36 hrs/wk, 6 hrs of evenings/weekends
 - #3 32 hrs/wk, 12 hrs of evenings/weekends
 - #4 28 hrs/wk, 18 hrs of evenings/weekends
- A 385 - Physician Multispecialty Clinic

Contact Patrick Moylan at 612-932-5986
or Send CV and letters of inquiry to:
Physician Recruitment
Park Nicollet Medical Center
3800 Park Nicollet Blvd.
Minneapolis, MN 55416
or FAX 612-932-6490



Park Nicollet Medical Center
A HealthSystem MinnesotaSM member

Would you enjoy being nestled between Lake Superior and the BWCA?

This could be the next phase of your career!

If you love your practice, but are excited by new challenges, consider joining the physician faculty at the Duluth Family Practice Residency. While the residents benefit from your knowledge of practice in the '90s, you will flourish in one of the most livable cities in the country.

**Would you enjoy a collegial practice with specialists of all types?
Have you dreamed of working where you like to play?**

Applicants must hold M.D./D.O. degree, be ABFP certified and have, or be eligible for, a Minnesota license. Practice experience with obstetrics is required. Teaching experience and knowledge of family practice in the managed care setting are desirable. Responsibilities include teaching residents, administrative/research, and patient care. The affiliated School of Medicine in Duluth provides opportunities to teach medical students.

**To apply, submit a letter of interest, a curriculum vitae,
and names of 3 references before May 15, 1995, to:**

ROGER K. WAAGE, M.D.
Chair, Faculty Search Committee
Duluth Family Practice Residency Program
330 North 8th Avenue East
Duluth, MN 55805 • 218/725-2601

*The Duluth Family Practice Residency Program
has an academic affiliation with the University of
Minnesota Duluth and is an equal opportunity
educator and employer.*



**THIS
PUBLICATION
AVAILABLE
FROM UMI**

This publication is available from UMI in one or more of the following formats:

- In Microform--from our collection of over 18,000 periodicals and 7,000 newspapers
- In Paper--by the article or full issues through UMI Article Clearinghouse
- Electronically, on CD-ROM, online, and/or magnetic tape --a broad range of ProQuest databases available including

abstract-and-index, ASCII full-text, and innovative full-image format

Call toll-free 800-521-0600, ext. 2888, for more information, or fill out the coupon below:

Name _____

Title _____

Company/Institution _____

Address _____

City/State/Zip _____

Phone () _____

I'm interested in the following title(s): _____

UMI
A Bell & Howell Company
Box 78
300 North Zeeb Road
Ann Arbor, MI 48106
800-521-0600 toll-free
313-761-1203 fax



People and Places Making Medical News

People

.....

New Transplant Chief at 'U'

The University of Minnesota has appointed **David Sutherland, M.D.**, to succeed **John Najarian, M.D.**, as the school's head of organ transplantation. Najarian resigned from the position in February but continues his private practice at the university.

Sutherland, a pancreas transplant surgeon, will direct the kidney, pancreas, islet cell, liver, and bowel transplant programs. He is a graduate of the university's Medical School and has been with its Surgery Department since 1976. **R. Morton Bolman III, M.D.**, will continue to direct the heart, heart-lung, and lung transplant programs.

RCMS President

John R. Balfanz, M.D., was installed as the 124th president of the Ramsey County Medical Society at its Annual Meeting in January. Balfanz is a pediatrician with the Pediatric and Young Adult Medicine Clinic in St. Paul and an associate clinical professor with the Department of Pediatrics at the University of Minnesota.

Other officers inducted were **Kenneth W. Crabb, M.D.**, president-elect; **Lyle J. Swenson, M.D.**, secretary; and **William M. Rupp, M.D.**, treasurer.

RCMS Community Service Award

Ramsey County Medical Society presented its third annual Community Service Award to **Timothy Rumsey, M.D.**, of United Family Practice, at its annual meeting in January. Rumsey was selected to receive the award primarily for his dedication to the homeless of St. Paul. He has volunteered since 1982 with the Health Care for the Homeless Project in Ramsey County, which provides health care services to people without perma-

nent shelter in Ramsey County and assists them with other special needs. He also practices at a weekly walk-in clinic located at the Dorothy Day Center and coordinates the Homeless Pharmacy project. In addition to practicing medicine, Rumsey is a successful novelist.

AAOS Board

The American Academy of Orthopaedic Surgeons has re-elected **Bernard F. Morrey, M.D.**, and appointed **Richard F. Kyle, M.D.**, to its board of directors.

Morrey is a professor and chair of the Department of Orthopedic Surgery at the Mayo Clinic in Rochester, Minnesota. He has been active in the academy since 1979 and served on its board of directors in 1985 and from 1992 to 1994.

Kyle, an orthopedic surgeon, is president of Wayzata Orthopedics, P.A., and an associate professor in the Department of Orthopaedic Surgery at the University of Minnesota in Minneapolis. He also is chair of the Orthopaedic Surgery Department and medical director of the Orthopaedic Biomechanics Laboratory at Hennepin County Medical Center.

Medintell CEO

Kevin Roberg has been named chief executive officer of Medintell Systems Corp., a Minneapolis-based company that markets a medication management system to hospitals. Roberg has more than 20 years' experience in the health care and insurance industries. Previously, he was president of EBP Western HealthPlans, a subsidiary of Employee Benefit Plans, Inc., one of the largest administrators of self-funded health care plans in the country.

Medintell's product, PreciseCare, was developed by the Mayo Clinic to track medication from the time of the order to delivery to the

patient. Medintell is a licensee of the Mayo Foundation and has exclusive rights to distribute PreciseCare worldwide.

Places

.....

'U' Boosting Gene Therapy Research

The University of Minnesota is establishing a gene therapy research center to be housed in its ALG drug production building, which was built in 1991 on the St. Paul campus but was never used. The center will bring together various research programs currently underway in such areas as bone marrow transplantation and cell and gene therapeutics. The university expects the center will be supported by grants from the National Institutes of Health and possibly through partnerships with businesses in the community.

William Brody, M.D., health sciences provost, said the university has been a leader in inventing and producing medical devices, but it has not been as strong in biomedical technology. "This will put the University of Minnesota ahead of the pack in gene therapy," he said in a Minneapolis-based *Star Tribune* article.

The ALG program never moved into the drug production building, which has a number of high-tech features, because the U.S. Food and Drug Administration halted the distribution of ALG following the discovery that the drug had never been licensed for sale. Profits from the sale of ALG over 20 years paid for the St. Paul campus facility.

Mayo Building New Hospital

The Mayo Clinic is planning to build a new hospital in Scottsdale, Arizona, that will include such features as electronic medical records and rooms that accommodate patients' families. The \$80 million hospital will have 132 beds

and employ 600 to 700 people. It will be the first hospital Mayo has built from the ground up.

Socioeconomics

BCBSM Cutting Small Business Rates, Expanding Coverage

Blue Cross and Blue Shield of Minnesota is reducing its health coverage rates for small businesses by 5 percent to 6 percent effective July 1 and is increasing the lifetime maximum coverage per enrollee from \$1 million to \$2 million. BCBSM attributed the cuts to MinnesotaCare reforms that went into effect in July 1993 as well as to increased use of managed care. The rates will save approximately \$700 per year for employers with an average group size of seven employees.

Among its reforms, MinnesotaCare prohibits insurance carriers from denying coverage based on previous illness, and it provides for a large reinsurance pool that pays the cost of catastrophic illnesses. The reinsurance pool gives BCBSM a safety net that allows it to lower premiums.

MinnesotaCare Costing Less than Projected, Saving Money

A study shows that MinnesotaCare is saving the state's Medicaid program \$80,000 per month because approximately 2,400 fewer people are on Aid to Families With Dependent Children since MinnesotaCare began, according to George Hoffman, director of reports and forecasts for the Minnesota Department of Human Services. "They are either leaving AFDC or are not going on AFDC—probably a combination of both—because the availability of health insurance makes it possible for them to make it on a job that does not provide health insurance," he told the *St. Paul Pioneer Press*.

Nonetheless, health officials are trying to tighten the screening of new MinnesotaCare enrollees because an audit showed that for 17.2 percent of the 737 cases reviewed, at least one family

member should have been disqualified from the program. At least 9.4 percent of the individual enrollees analyzed were ineligible. Five cases of fraud were discovered. Most of the enrollment errors are complex and not fraudulent mistakes, but program officials are nevertheless tightening the screening process.

Meanwhile, legislators this session are asking the state to ease eligibility requirements because, with healthier than expected enrollees, MinnesotaCare has operating costs 22 percent below earlier forecasts. The cost of running the program over the next five years will be about \$150 million less than the \$650 million originally projected, according to Hoffman. Based on this forecast, MinnesotaCare could have a nearly \$220.4 million surplus by the end of fiscal year 1999, said Kirsten Libby, budget officer for the state Finance Department.

St. Cloud Groups Integrating

The St. Cloud Clinic of Internal Medicine and St. Cloud Hospital have signed an agreement to develop an integrated health care delivery system that would join the two corporations into a nonprofit health care organization called CentraCare. The groups expect the integration to take place in June.

The two groups believe integration is the best way to meet common goals for health care quality, cost, and access. Planned changes include adding an integrated computer system to ease communications, clarifying responsibilities in order to eliminate duplication, offering greater assistance to the uninsured and underinsured before their health needs become critical and costly, enhancing physician recruitment, further streamlining the health care delivery process, and assuring consumer choice in the local health care market.

State Examining Drop in Licensed Physicians

A greater than average number of physicians gave up their license to practice medicine in Minnesota in

1993, and state researchers are conducting a survey to investigate why. A preliminary analysis shows that 2,365 doctors—1,126 of whom lived in Minnesota—did not renew their licenses in 1993. Health care experts wonder why the total is so much higher than the 471 license expirations in 1992 and 744 in 1991.

H. Leonard Boche, executive director of the Minnesota Board of Medical Practice, said the number of active physicians has already rebounded from what he called a temporary downturn. However, Dale Bergeron, program director of the Minnesota Center for Rural Health, said the reason may be that many health system reform measures have made Minnesota "not a friendly state" for physicians.

Some researchers suspect the drop is related to the \$400 surcharge on licenses that took effect in 1993. Retired physicians and those living in other states may have decided that renewing the license was not worth the cost. (The law was later amended to exempt doctors who use their licenses only to contribute their medical services as volunteers.)

Audit Finds No Proof 'U' Doctors Accepted Kickbacks

A University of Minnesota audit found no reason to believe doctors at the university's Medical School are taking kickbacks from Caremark Inc. However, the federal government is also investigating because the issue involves Medicare and Medicaid money.

University physicians and Caremark, an Illinois company that provides home infusion services, formed a corporation in 1991. Caremark has paid the physicians more than \$2 million for providing procedures and technology to use as a "model" of managed care for home infusion therapy. The physicians referred patients to Caremark, which raised the question of whether the physicians were actually paid for the referrals. It is illegal to pay or receive payment for referrals to a service funded by Medicare or Medicaid.

The auditors said the relationship between the physicians and Caremark was legally defensible—the doctors provided something of value to Caremark in the form of clinical standards, advice, coordination, and education.

Medical Research

Mayo Finds Blood Test Helps Identify Heart Attack Patients

A fast, inexpensive blood test can help physicians better identify which emergency room patients with chest pain are actually having a heart attack, according to a Mayo Clinic study published in the March *Annals of Internal Medicine*. The test, which measures a change in the number of white blood cells in circulation, more accurately identifies heart attack when used in combination with other blood tests.

"We found that the test measuring white blood cells worked well alone, but when combined with other blood tests, it worked spectacularly," said Mayo cardiologist Raymond Gibbons, M.D. "By using this combination of tests, we were able to identify many more patients with heart attacks within the first half hour of arrival in the emergency room."

Researchers tested the hypothesis that the body's stress response, which causes a change in the number of white cells in the blood, could be an accurate marker for heart attack. Electrocardiography and blood tests to identify heart-muscle damage traditionally have been used to make a diagnosis.

"Most patients who have a heart attack do not have diagnostic electrocardiographic changes," said Gibbons. "As a result, they don't get aggressive therapy and, many times, die in the hospital. In this study, we tried to find a better way to identify these patients so appropriate therapy could be given."

Over a six-month period, a multidisciplinary team led by Stephen Thomson, M.D., studied 384 patients aged 20 and older who came to the emergency room

with chest pain. Each patient had an electrocardiogram and blood tests to diagnose heart attack. The researchers then compared the accuracy of each test.

Of the 69 patients who had a heart attack, only 27 (39 percent)

were identified by the electrocardiogram. In contrast, an additional 17 patients (25 percent) were diagnosed early by using the white blood cell count and another rapid blood test. The Mayo investigators estimate that this approach would

Join a medical group rich in support in an area rich in natural beauty

When you join Duluth Clinic, you become part of a 275-physician multispecialty group offering the professional autonomy you want with the economic resources and financial stability you require. As a regional referral center, Duluth Clinic serves over 500,000 people in northern Minnesota, northern Wisconsin and upper Michigan through its Duluth location and a network of 14 regional centers. Rewarding opportunities are currently available for BC/BE physicians in the following areas:

<i>Family Practice</i>	<i>Orthopedics</i>
<i>Emergency Medicine</i>	<i>Electrophysiology</i>
<i>Internal Medicine</i>	<i>Cardiology</i>
<i>Neonatology</i>	<i>Occupational Medicine</i>
	<i>Rheumatology</i>

Experience the scenic beauty and outdoor pleasures found only by the beautiful shores of Lake Superior, and nearby Boundary Waters Canoe Area Wilderness.

Please send CV to Michael Griffin, Duluth Clinic, 400 E. Third St., #500-2, Duluth, MN 55805; or call 1-800-342-1388 or 218-722-8364. An equal opportunity employer.

Duluth Clinic
A Regional Health Care System

identify about 250,000 more people experiencing heart attacks each year. Mayo is already using the test in its emergency room.

Mayo Tests Successful Drug Therapy for Colon Cancer

Mayo researchers have found that a combination of the drugs 5-FU and levamisole reduces cancer recurrence by 40 percent and death rates by 33 percent, according to a study published in the March *Annals of Internal Medicine*. The recently deceased Charles Moertel, M.D., discovered the treatment in the late 1980s, and the FDA approved it in 1990 after a preliminary study showed it was effective.

In the current study, headed by Moertel, investigators from the North Central Cancer Treatment Group, the Southwest Oncology Group, and the Eastern Cooperative Oncology Group followed 929 patients whose colon cancer had spread to nearby lymph nodes. After surgery, the patients were randomly assigned to one of three

groups: no additional treatment, levamisole alone, or a combination of levamisole and 5-FU. The patients were monitored for at least five years. Of the 315 who received no additional treatment, 177 experienced a recurrence of cancer and 168 died. Of the 304 patients who received 5-FU and levamisole, 119 had a cancer recurrence and 121 died. Levamisole alone did not appear to improve the rate of cancer recurrence or survival. The combination treatment doesn't just prevent the onset of new cancer but actually cures patients, said Mayo oncologist Michael O'Connell, M.D., in a recent *St. Paul Pioneer Press* article.

The study was one of three Moertel was working on when he died in June after a long illness, the *St. Paul* newspaper reported.

Cystic Fibrosis May Increase Risk of Digestive Cancer

A University of Minnesota study found that cystic fibrosis may increase a patient's risk of develop-

ing cancer of the digestive tract, but the overall risk of cancer in patients with cystic fibrosis is similar to that of the general population, according to a report in the February 23 *New England Journal of Medicine*. Patients with cystic fibrosis have a 6.5 times higher than average risk of developing digestive cancer than the average person of the same age, gender, and race, according to Joseph Neglia, M.D., the pediatric cancer specialist who headed the study. The study of 28,511 cystic fibrosis patients in the United States and Canada and the records of cystic fibrosis patients in 17 European countries suggests more digestive tract cancers will occur as the life span of patients with cystic fibrosis increases. Because of improved care, one-third of all cystic fibrosis patients now reach adulthood.

Neglia said physicians should monitor cystic fibrosis patients for early signs of cancer of their digestive systems. **MM**

PHYSICIAN

RURAL PHYSICIAN ASSOCIATE PROGRAM

The Rural Physician Associate Program (RPAP) at the University of Minnesota is looking for residency-trained, board-certified family physician to join the Medical School at the rank of Physician (annual, salaried, renewable 20-50% appointment).

Duties of position include regular travel throughout Minnesota by car and plane for teaching third year medical students both individually and in groups. Further activities could include educational research and publication on all components of RPAP and administrative tasks associated with the operation and maintenance of the program. Some of these tasks could include the coordination and hosting of recruitment and orientation sessions, selection and evaluation of new students and communities, creation of educational materials, assist in scheduling and student/program evaluation, support of the statewide and local area computer networks, and the funding of projects and programs through grant writing. Knowledge of RPAP, Minnesota, Macintosh and IBM computing research design and statistical analysis is encouraged. Salary is commensurate with training and experience.

Start date is negotiable; applications will be considered through April 30, 1995. Send CV to: W. Swenko, M.D., M.S.

Director, RPAP
Box 81, UMHC
420 Delaware St. SE
Minneapolis, MN 55455
612-624-3111

UM

The University of Minnesota is an equal opportunity educator and employer.

GENERAL INTERNISTS

Hennepin County Medical Center, a University of Minnesota-affiliated teaching hospital, seeks a General Internist to join the Internal Medicine Clinic group practice within the Department of Medicine. Candidates should demonstrate strong clinical abilities; possess strong interest, experience, and commitment in managed care with an emphasis in ambulatory care; and display effective educational skills. Responsibilities include providing medical care and teaching medical students and housestaff.

Depending upon experience and qualifications, the candidates would be eligible for a full-time, renewable-term University academic appointment at the Clinical Instructor level or above, with the approval of the Department of Medicine and the Promotions and Appointments Committee of the University of Minnesota Medical School.

The University of Minnesota and Hennepin Faculty Associates are equal opportunity educators and employers, who specifically invite and encourage applications from women and minorities.

Please submit letter of interest and curriculum vitae to:

Henry T. Smith, M.D.
Department of Medicine
HFA Internal Medicine Clinic, Suite 206
Hennepin Faculty Associates
825 South 8th Street
Minneapolis, MN 55404
612-347-7534

Last day for receipt of information: April 30, 1995.

Just minutes from your back door and you're into some of the only real, NATURAL wilderness areas remaining in America.

Isn't it time to get away?

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park—two natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd., a 30-physician, multi-specialty clinic, currently has openings in family practice, internal medicine and orthopedics. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:
Bill Doran, Physician Recruiter
910 Sixth Avenue North
Virginia, MN 55792
1-800-377-3290 or
218-741-0150

East Range Clinics LTD 

ASSOCIATE MEDICAL DIRECTOR

Employers Health Insurance, a wholly owned subsidiary of EMPHESYS Financial Group, is the nation's 10th largest group health insurer. We currently have a challenging and rewarding position available in our Corporate headquarters located in Green Bay for an Associate Medical Director.

The position will be responsible for assisting the Medical Director with strategic planning, and making recommendations for case management to claims and underwriting management.

Requirements include Board Certification in internal medicine or family practice, eligibility for state licensure, and at least 2 years of medical practice experience. Service on a hospital peer review, utilization review, quality assurance committee, or as a Medical Director of an HMO is essential.

Employers Health Insurance offers a challenging work environment along with a competitive salary and flexible benefit package including 401 (k) and profit sharing. Please send resume to: **Human Resources, EMPLOYERS HEALTH INSURANCE, 1100 Employers Blvd., Green Bay, WI 54344.** An equal opportunity employer.



EMPLOYERS HEALTH INSURANCE
EMPHESYS
FINANCIAL GROUP, INC.

GENESIS REGIONAL HEART CENTER

Friday, July 28, 1995
Jumer's Castle Lodge
Bettendorf, Iowa

**CARDIOLOGY
AT
THE
BIX**

PUTTIN' ON THE BIX: MUSIC AND MEDICINE

Now in its fifth year, Cardiology at the Bix, sponsored by Genesis Regional Heart Center features internationally acclaimed speakers, as well as attendees from all over the country. Held at the beautiful Jumer's Castle Lodge in Bettendorf, it draws internationally acclaimed physicians.

Attendees can also enjoy the Bix Beiderbecke Memorial Jazz Festival, which features top-notch bands from around the world and honors Davenport native son and jazz great Bix Beiderbecke.

More than 20,000 runners are expected for what Runner's World calls "the road race with the most community spirit." Scheduled for July 29, the Bix 7 is the eighth largest road race in the United States.

REGISTRATION INFORMATION:

Registration Fee: \$95 Physician \$55 Nurse/Allied Health Professional
Fee includes attendance at the symposium, a ticket to the 'Friends of Bix' Cocktail Party, and a complimentary dinner aboard the Casino Rock Island.

Registration deadline is July 3, 1995. Confirmation and entertainment details will be sent upon registration. For further information, please contact Anne Pauly (319) 383-1062.



**GENESIS
MEDICAL CENTER**

Genesis Regional Heart Center
1227 East Rusholme Street
Davenport, Iowa 52803

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

A P R I L 1 9 9 5

Apr. 6-7 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 6-7 **Fifteenth Annual Pediatric Update** Dakota Medical Center; Doublewood Inn, Fargo, ND. CONTACT: Deb Clemenson, Dakota Hospital, 1720 South University Street, Fargo, ND 58103; 701/280-4546.

Apr. 6-9 **Second International Conference on the Medical Aspects of Telemedicine and Second Annual Mayo Telemedicine Symposium** Mayo Foundation, World Health Organization, and the Agency for Health Care Policy and Research; Rochester, MN, Scottsdale, AZ, and Jacksonville, FL. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 7 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 8 **Helicobacter Pylori** Allina Health System; Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 8 **Problems in Clinical Anesthesia-Department of Anesthesiology Clinical Symposium** University of Minnesota Anesthesiology Department; Radisson Metrodome, Minneapolis, MN. CONTACT: David S. Beebe, M.D., Box 294, B515 Mayo, Department of Anesthesiology, 420 Delaware Street SE, Minneapolis, MN 55455; 612/624-9990.

Apr. 9-12 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 12 **Infectious Disease Update/TB/Hepatitis/HIV** St. Joseph's Medical Center; St. Joseph's Medical Center, Brainerd, MN. CONTACT: S.J. Bode, Resource Coordinator, 523 North 3rd Street, Brainerd, MN 56401-3098; 218/828-7414.

Apr. 21-22 **Eighteenth Annual Update on Clinical Cardiology** Allina Health System; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 24-25 **Advanced Trauma Life Support (ATLS)** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 28 **Allergy and Clinical Immunology** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Apr. 28-29 **Minnesota Orthopaedic Society Eleventh Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

Apr. 29 **Controversies in Prostate Cancer** Allina Health System; Radisson South, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

M A Y 1 9 9 5

May 1-5 **Family Practice Review and Update** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Infection Control Courses

The following course has been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

M A Y 1 9 9 5

May 5-6 **Common Infections of Mothers and Infants-Prevention and Management** Children's Health Care, Minneapolis/St. Paul; St. James Hotel, Red Wing, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/863-5884.

May 5-6 **Annual Ophthalmology Course** University of Minnesota CME; Park Inn, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 6 **A Current Update on Evaluation and Treatment of Infertility** Minnesota Urological Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

May 8-12 **Sixteenth Annual Practice of Internal Medicine** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 9 **Gynecology & Gynecologic Oncology** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 10-12 **Current Concepts in Radiation Therapy** University of Minnesota/Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 18-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

May 18-20 **Temporal Bone Dissection** University of Minnesota/Continuing Medical Education; Phillips Wangenstein Building, University of Minnesota, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 19-20 **Phonosurgery: Indications and Techniques** Hennepin County Medical Center/Hennepin Faculty Associates; Hennepin County Medical Center, Minneapolis, MN. CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

May 20-21 **First Annual Minnesota Vascular Diseases Symposium** University of Minnesota/Continuing Medical Education; Northland Inn, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

MMA-Accredited CME Sponsors

• The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor CME activities for local physicians. • Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating the amount and category of credit for CME activities. • CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and "Standards for Commercial Support of CME." •

The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- Immanuel-St. Joseph's Hospital, Mankato
- Methodist Hospital, Minneapolis
- Ridgeview Medical Center, Waconia
- St. Luke's Hospital, Duluth

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

You'll know you're putting down roots when ■■■■■

...You're a "regular" on our nationally acclaimed biking and cross-country skiing trails in Monroe, Wisconsin...You audition for a part in our theater guild productions...You practice soccer, swimming, basketball or Tae Kwon Do with your family at the local "Y"...You coax your favorite perennials to brilliance beside a lawn as lush as the farms that cover 90% of the county.

The coveted standard of living in our community of 10,000 complements the professional environment that awaits you at The Monroe Clinic—a consolidated and integrated healthcare facility combining a new 114,000 sq.ft. clinic adjoining a state-of-the-art, 140-bed acute care hospital with 24-hour ER coverage. Here and in branch clinics in south central WI and northwestern IL, our 50+ physician multispecialty group provides family oriented health care. You can play a key role as a BC/BE physician in:

- Family Practice
- OB/GYN
- Cardiology (non-invasive)
- Outpatient Psychiatry
- Orthopedic Surgery
- Pulmonology
- Dermatology

We offer comprehensive benefits and productivity based pay with excellent 1st year income guarantee; freedom from office management and buy-in costs; potential for research/academic appointments, and a prime location just two hours from Chicago and Milwaukee and one hour from Rockford, IL, Madison, WI and Dubuque, IA. Call 800-373-2564 or send CV to: Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. Or fax resume to 608/328-8269. EOE.



The Monroe Clinic
A proud caring tradition

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine
Internal Medicine
General Surgery

OB/GYN
Otolaryngology
Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469



**Columbia Park
Medical Group**

- OB/GYN ● BC/BE Specialists
- Family Practice ● Internal Medi-

OB/GYN:

Three BC Physicians are looking for a fourth to join in their busy practice.

FAMILY PRACTICE: Join group or do locum tenens
Join 27-member Family Practice Department
with call one weekday per month and one weekend day per month

INTERNAL MEDICINE:

Seven-member department has busy hospital and clinic practice.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered.

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Kay Duffney
(612) 586-5876

Chief of Professional Services Coon Rapids Family Medical Center Coon Rapids, MN

Group Health, Inc., is seeking a BC/BE family practice physician interested in pursuing an important leadership role at our Coon Rapids Family Medical Center while maintaining a clinical practice.

The Chief of Professional Services is the physician manager of the clinic and is involved with day-to-day operations and staffing decisions while maintaining his/her clinical practice. The chief receives administrative support from the clinic manager and the Group Health administrative and physician management team.

Group Health provides many opportunities for professional growth and development. Many of our physicians conduct research funded by our Group Health Foundation. In addition, Group Health offers

its physicians competitive salaries and generous benefits including two weeks of paid time off for continuing medical education.

If you are interested in this challenging opportunity, please call Ann Mliner at (612) 883-5337, (800) 472-4695, or send CV to: Group Health, Inc.; A Division of HealthPartners; Physician services; Attn: Ann Mliner; 8100 34th Ave. S; P.O. Box 1309; Minneapolis, MN 55440-1309; EO/AA Employer.



HealthPartners

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., April 15 for June ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine, Physicians Assistant to join progressive 11-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician,

multispecialty practice located just south of the Twin Cities on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

LaCrosse, Wisconsin

- Live in beautiful Mississippi River Valley.
- Work with high quality colleagues in growing multispecialty group (70 Physicians).
- Competitive income/benefits.

Specialists Needed

Cardiology (Non-Invasive)
Critical Care/Pulmonary Medicine
Dermatology
Emergency Medicine
Family Practice
Internal Medicine
Neurology
Occupational Medicine
Orthopedic Surgery
Pediatrics
Urology

Send CV to:

P. Stephen Shultz, M.D.
SKEMPCLINIC
800 West Avenue South
La Crosse, WI 54601
Fax (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612.763.5123

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/ Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Donald Weinshenker, M.D.
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.

Internal Medicine—Carroll, Iowa: Outstanding opportunity for an internal medicine physician in a progressive, safe, and clean community of 10,000 located in west-central Iowa, 90 miles from Des Moines, Iowa, or Omaha, Nebraska. Excellent schools (Catholic and public), quality hospital featuring a radiation oncology center, dialysis center, and a new 32,000 square-foot outpatient addition. Significant income potential available. For more information, call Randy Simmons, Vice President, St. Anthony Regional Hospital, 800/382-4197. *6-4/95

Primary Care Physicians and Subspecialists are being sought for a variety of group practices located throughout the upper Midwest and New York state. Choose from metropolitan cities, college towns, popular resort communities, or traditional rural destinations. This month, opportunities available for physicians specializing in family practice, internal medicine, pediatrics, occupational medicine, hematology/oncology, and nephrology. New opportunities monthly! For all of the facts, call 800/243-4353, or write to: Strelcheck and Associates, 10624 North Port Washington Road, Mequon, WI 53092. *3-4/95

Whitefish Lake Retreat with all amenities on best "chain of lakes" in Minnesota, just minutes from Brainerd. Five bedrooms, four baths in shared 300-acre preserve with tennis court. Includes use of canoe, 14-foot fishing boat, and sailboat. Excellent swimming. \$2,100 per week. 612/228-1104. *1-4/95

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-5237 MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.

PHYSICIAN WANTED

Community Care for the Elderly is looking for a board certified internist or family practitioner with an interest in the care of the elderly. The position offers a position to care for the frail elderly of the community in an adult health care center and clinic. An understanding of the elderly and the ability to work with a multidisciplinary team is needed. The positions available are for part-time and full-time practice. Interested individuals should contact:

Mary Gavinski, M.D., Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
414-536-2110, ext. 254

NURSES!

ENHANCE YOUR CAREER ★ BECOME A NAVAL RESERVE NURSE
\$18,000-\$30,000 BONUSES

Motivated nurses around the United States are enhancing their leadership skills by joining the Naval Reserve Health Care Team. Through this flexible, part-time opportunity you can experience the pride and prestige of being a Naval officer. Serve your country with other medical professionals while you receive training in military medicine. If qualified, you may be eligible

for a \$6,000 to \$10,000 yearly bonus for three years in addition to a competitive pay and retirement package. Other benefits include financial assistance for advanced nursing education, worldwide travel opportunities, shopping at military stores, and full-time term life insurance.



If you would like to know more about wearing the gold of a Naval Reserve nurse, call:

1-800-633-3209

INSTRUCTOR/ASSISTANT PROFESSOR

Department of Laboratory Medicine and Pathology
Hennepin Faculty Associates

The Department of Pathology of Hennepin Faculty Associates is seeking a junior staff level Pathologist for surgical pathology and cytology services performed at Hennepin County Medical Center. The surgical pathology division processes 10,000 specimens per year, and responsibility for this division is shared by several staff members. The cytology service processes 15,000 specimens per year, including over 600 FNA's, and responsibility for this service is shared with other staff. In addition to the above responsibilities, the new staff member will be responsible for postmortem examinations, demonstrate skills in teaching medical students and residents, and will be encouraged to develop an independent research/scholarly program.

Hennepin County Medical Center is a large metropolitan hospital affiliated with the University of Minnesota. The successful candidate will also hold an academic faculty appointment without salary in the Department of Laboratory Medicine and Pathology at Instructor or Assistant Professor level (temporary annually renewable) at the University.

Qualifications are: M.D., Board certified or eligible in Anatomic and Clinical Pathology.

Applications and curriculum vitae may be submitted to Gretchen Crary, M.D., Department of Pathology (815), Hennepin County Medical Center, 701 Park Avenue, Minneapolis, MN 55415, by May 1, 1995.

Hennepin Faculty Associates and the University of Minnesota are equal opportunity educators and employers.

Lake City Clinic—Family Physicians: *Travel & Leisure* magazine calls Lake City and Lake Pepin "wild, magical, unspoiled, undiscovered" and "a world apart" (6/94). Why live and work elsewhere when opportunities for family physicians exist in Lake City? Join four other FPs and share in a broad range of benefits and generous income. Please contact Frank Thorngren, M.D., Lake City Clinic, P.A., 303 South Washington Street, Lake City, MN 55041; 612/345-3318. Fax: 612/345-3435. 1-4/95

Community Clinic providing neighborhood-based health care is seeking physician to compliment current staff of MDs, mid-level practitioners, health education and mental health professionals. Candidates should be BC/BE in internal medicine or family practice. Full time or part time, we're flexible! Serve diverse populations. Call or write Nancy Briggs, Executive Director, North End Medical Center, 135 Manitoba Avenue, St. Paul, MN 55117; 612/489-8021. *2-5/95

Family Physician to join the medical staff of five family practitioners in a well-established growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Excellent subspecialty support, progressive community hospital, diverse patient population. Guaranteed fringe benefits program with a payback program. Call collect, 612/532-3154, or write Frederick W. Haack, Administrator, Mille Lacs Health System, PO Box A, Onamia, MN, 56359. *6-9/95

PRACTICE MEDICINE THE WAY YOU INTENDED



Navy medical professionals make the most of practicing medicine. For them, the emphasis is on the patient – not paperwork.

Navy doctors are part of an active and challenging group practice. You work with state-of-the-art equipment at some of the best facilities available.

Highly trained physician's assistants, hospital corpsmen, nurses and hospital administrators assist with the paperwork. As a result, doctors are freer to look after the needs of the patients.

The benefits don't stop there... you also enjoy the lifestyle of a Navy officer. This includes comparable medical salaries and 30 days paid vacation earned each year.

To learn more about the Navy's practice made perfect, send your CV or call: Navy Medical Opportunities Office
212 Third Avenue South
Minneapolis, MN 55401-2592
1-800-247-0507

NAVY PHYSICIAN You and the Navy.
Full Speed Ahead.

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Family Practice	Pediatrics
Internal Medicine	Neurology
Orthopedic Surgery	OB/GYN
Noninvasive Cardiology	Urology

Send your CV to Gary Luiten, St. Francis, Inc.,
4541 North Prospect, Suite 400, Peoria, IL
61614; or call 800/862-9012.

Occupational Medicine—Minneapolis: BC/BE occupational medicine physician needed to join Occupational Health-System Minnesota of Park Nicollet Medical Center. We are a 385-physician multispecialty clinic in the desirable Twin Cities area. Physicians who are BC/BE in family practice or internal medicine, with experience or strong interest in occupational medicine, are also encouraged to apply. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at 612/993-3286, or send CV and letters of inquiry to Physician Recruitment, Park Nicollet Medical Center, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; or Fax, 612/993-2819. *2-4/95

Family Practice/General Surgeon/Pediatrician, BC/BE, to join progressive 26-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. *3-5/95

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. 3-6/95

Family Practice—North St. Paul, Minnesota: Family practice group of four seeks to fill vacancy. Full range of family practice with ob/pediatrics/geriatrics. Stable community clinic since 1946 with excellent growing patient population. Hospital affiliation is St. John's Northeast and Health-East facilities. Opportunity for one-year salaried position with subsequent buy-in to partnership. Clinic is associated with East Metro Health Organization with multiple insurance contracts. Contact Mary Dennison, M.D., 2579 East Seventh Avenue, North St. Paul, MN 55109; 612/777-7414. *3-6/95

Not Just Another Recruitment Ad: Opportunities at North Memorial-owned and -affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs, and ob/gyns thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs call 800/275-4790, or fax CV to 612/520-1564. 1-4/95

WISCONSIN

MINNESOTA

MICHIGAN

ILLINOIS

IOWA

NEW YORK

Great Lakes Great Life

Strelcheck and Associates, a respected search firm, invites you to consider a wide variety of group practice opportunities in the *Great Lakes Region*. Whether you prefer a metropolitan/suburban city, scenic college town, restful resort community, or something in-between, we have the setting for you! Many prominent groups and hospitals have come to rely on our professional approach to physician staffing. Call us toll-free at 800-243-4353 so we can earn your trust as well.



Strelcheck and Associates, Inc.

10624 N. Port Washington Road
Mequon, WI 53092

FAMILY PRACTICE

INTERNAL MEDICINE

PEDIATRICS

HEM/ONC

NEPHROLOGY

OUR HIGH GROWTH LOCALE Means Expanding Opportunity

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director

COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

La Crosse, Wisconsin

BC/BE general pediatrician to join four pediatricians in growing multispecialty group (70 physicians). Competitive guaranteed income/benefits. Affiliation with local hospital system and major medical center expected. Desirable midwestern, small city in beautiful Mississippi River Valley. Great family atmosphere, excellent schools and recreation opportunities.

Send CV to:

P. Stephen Shultz, M.D.
SKEMP CLINIC
800 West Avenue South
La Crosse, WI 54601
Fax (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

APRIL 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Army Reserve	41
Aspen Medical Group	22
Central Minnesota Group Health Plan	18
C.F. Anderson Co., Inc.	27, 49
Chisago Health Services	58
CNA Insurance	9
Columbia Park Medical Group	58
Community Care Organization	61
Comprehensive Medical Care	63
Dodson	Cover 2
Duluth Clinic	53
East Metro Community Health Network	18
East Range Clinics	55
Employers Health Insurance	55
Fairview Clinic Services	48
Family Practice Residency Program	50
Fargo Clinic MeritCare	18
Genesis Medical Plaza	55
Global Holidays	22
HealthPartners	31, 58
Heartland Health System	27
Hennepin Faculty Associates	54, 62
Leonard, Street & Deinard	30
LPL Financial Services	45
Mankato State University	61
Medica Foundation	8
Medical Protective Company	4
Minnesota Medical Business Resources	Cover 4, 32
Minnesota Physicians Insurance Agency	Cover 3
Monroe Clinic	57
Moonlight Home Health Care	64
Multicare Associates of the Twin Cities	30
Navy Recruiting District	62
Navy Reserve Recruitment Command	61
Norwest Center	45
Oxboro Clinics	41
Park Nicollet Medical Center	50
Ramsey Clinic	31
River Valley Medical Center	31
St. Cloud Hospital	41
St. Francis, Inc.	62
St. Luke's Midland Regional Medical Center	27
Skemp Clinic	60, 64
Sletto & Associates, P.A.	22
Strelcheck & Associates, Inc.	63
Stutzman-Helling	49
University of Minnesota	3, 54
Veterans Administration Medical Center	60
Webb Financial Group	17
Whitesell Medical Locums, Ltd.	26



DI Coverage: Going, Going...

Most physicians carry some sort of individual disability income insurance. From medical school on, doctors are approached time and again by agents and planners of all kinds, offering to review the coverage currently in force. The trend has always been one of better policy features and more and more aggressive marketing. In short, if one company wasn't willing to give the doctor the coverage he or she desired, there were literally dozens of other companies ready to fill the void.

End of an Era

But, those days are gone. In the last two months, the noncancellable individual disability insurance industry has seen the withdrawal of four of the major carriers, and other carriers have announced major changes to the types and costs of policies offered to physicians. Poor claims experience from these companies' 1985-1989 blocks of business, and especially poor claims experience with physicians in particular, has led these companies to take the actions stated above.

What Happened to DI?

In the simplest terms, overaggressive marketing and sloppy underwriting created a situation in which companies charged unrealistically low premiums and then had to pay more in claims than they had projected. Since the true financial performance of a disability product isn't known for several years, by

the time some of these DI underwriters realized what was happening, it was too late to take corrective action. Compounding the problem in the physician marketplace was the fact that large numbers of doctors were underwritten by these companies, and doctors made large numbers of claims over the past 18 months.

So Now What?

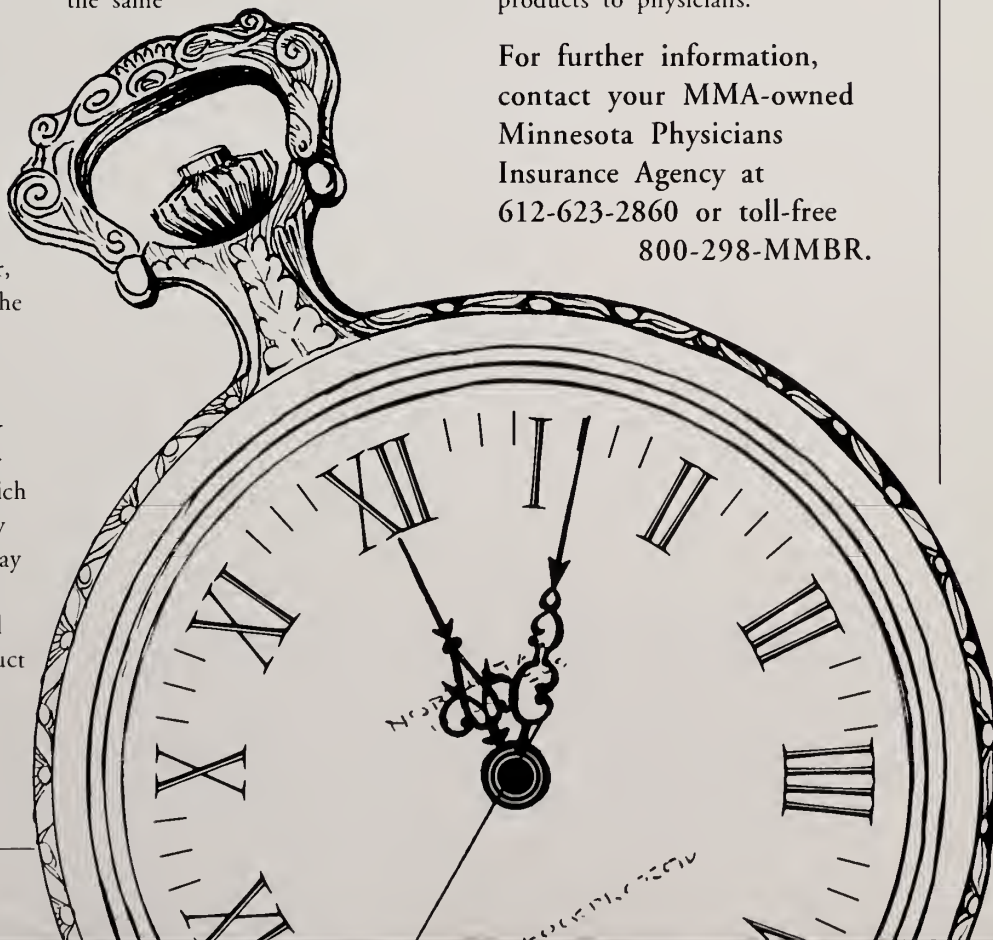
The net result is that physicians today are no longer preferred business by all carriers. And, what most doctors have now for individual disability income coverage is what they will have to stay with. There is, however, a very small window of time left for a review of that coverage, but within the next few months, the ability to purchase the same

quality DI contracts most physicians enjoy today will not be possible. Among the items that some carriers have scheduled for the chopping block are fixed premiums, "own occupation" protection, and voluntary rehabilitation benefits.

All Is Not Lost

Not all companies are pulling out of the individual disability income arena. Among the few who will remain is the MPIA-endorsed carrier, Paul Revere. As the nation's leading disability carrier, Paul Revere is better situated to weather the current storm. Although experiencing some of the same difficulties as other carriers, it has managed to remain profitable while offering competitive DI products to physicians.

For further information,
contact your MMA-owned
Minnesota Physicians
Insurance Agency at
612-623-2860 or toll-free
800-298-MMBR.



When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded after credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

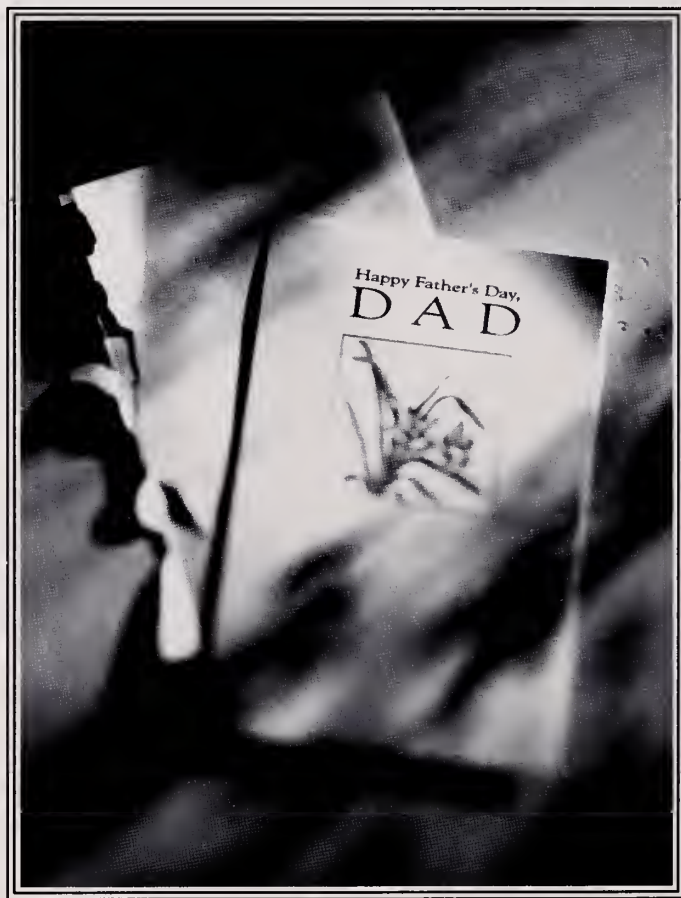
12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession
Pittsburgh, PA 15261-0001

How Does Capitation
Measure Up?

MAY 1995

For Over Forty Years, We've Made Sure These Have Gone To The Right People.

With its first parentage study in 1950, the Memorial Blood Centers of Minnesota initiated decades of genetic testing and a long-standing reputation of excellence. Under the directorship of Dr.



ing field. Throughout the years dedication to education, research and quality workmanship has set us apart. Today we deliver 99% probability of paternity from DNA and cell antigen test results in just 2 to 5 weeks.

H.F. Polesky, our facility has had a strong history of involvement in developing guidelines and standards for the parentage test-

very competitive fees. For more information on our parentage testing and related services please call 1-800-982-9154.

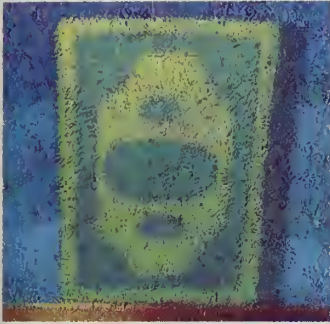


Memorial Blood Centers Parentage Testing

A non-profit organization. AABB Accredited.

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Rob Colvin.

DEPARTMENTS

- 2 MEDIA WATCH
- 5 EDITOR'S NOTEBOOK
- 28 AUTHOR INSTRUCTIONS
- 49 NEWS CLIPS
- 56 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

6 HIGHER OFFICE TO HIGHER LEARNING

Former U.S. Senator Dave Durenberger continues to shape health policy—not in the halls of Congress, but in the classroom, as an instructor and senior fellow at the University of St. Thomas.

EDITORIAL

8 CAPITATION WITHOUT TREPIDATION David E. Pautz, M.D.

Capitation arrangements can be both financially sound and professionally satisfying, says this doctor, who knows from experience.

FEATURE STORIES

10 DOLING OUT RISK: HOW CAPITATION MEASURES UP IN MINNESOTA

Allan Baumgarten, J.D., M.A.
Despite enormous interest in capitation, per-person pricing may have reached a plateau in Minnesota's health care market.

16 IS CAPITATION RIGHT FOR YOUR PRACTICE? Randall S. Vollertsen, M.D., M.B.A., and Robert B. Cumming, F.S.A., M.A.A.A.

Understanding the insurance risk, negotiating a fair contract, and controlling utilization are key to successful capitation.

MEDICINE LAW & POLICY

23 WHO BEARS THE RISK WHEN PHYSICIANS ARE ALSO INSURERS?

Gordon J. Apple, J.D.
The new world of capitation and risk sharing could compromise the physician-patient relationship.

CLINICAL & HEALTH AFFAIRS

29 CELIAC SPRUE IN AN ASYMPTOMATIC ELDERLY MAN

Nic R. Cordum, M.D.,
Brendan M. McGuire, M.D., and Douglas Nelson, M.D.

BOOK REVIEW

43 HISTORY'S ANSWERS TO MEDICINE'S TROUBLED PRESENT .. Seymour Handler, M.D.

Miguel Faria's "Vandals at the Gates of Medicine" offers a provocative overview of world history and how it relates to medicine today.

33 *The Monitor*

HIGHLIGHTS ... Legislative update—state reform bill advances, vulnerable adults bill amended • Viewpoint on direct contracting



Enough to Raise One's Blood Pressure

Let's assume you take antihypertensive medications. You also read your local paper, and, like most newspaper readers, you skim, reading the headline and the lead paragraph. Here's what you saw on the "Nation" page of the March 11 *Star Tribune*:

Some Blood Pressure Drugs May Be Dangerous

Six million Americans who are taking a class of drugs to lower blood pressure may instead be increasing their risk of heart attacks by 60 percent, researchers reported Friday.

Are you informed or scared? Does the word "may" in the lead sentence calm your fears, or is it overshadowed by "dangerous" or "60 percent more" heart attacks? What does "60 percent more" mean to the average reader? Most important, does the study quoted justify this headline and paragraph?

The Associated Press article identifies the culprit drugs as calcium channel blockers, then states, "National guidelines recommended the use of beta blockers and diuretics to lower high blood pressure." Calcium channel blockers have been used in recent years to treat high blood pressure, the article says, but recent studies show they "don't work very well"—yet physicians are still prescribing them for that purpose.

The reader has by this time gleaned these general points: 1) calcium channel blockers are dangerous; 2) they were considered effective for blood pressure but now are known to be worthless; and 3) dumb doctors continue to prescribe them. At a loss for why

these drugs are still being prescribed, the reader is told that "drug companies have marketed them beyond what the data shows." To solidify this conspiratorial connection in readers' minds, the article's final paragraph notes the fall in Pfizer and Merrell Dow stock the previous day.

What did the study really show? As presented at the American Heart Association, the study looked at 623 patients on antihypertensive medications who had had heart attacks, and it compared these patients with 2,032 patients on antihypertensive treatment who had not had heart attacks. The former group was 1.6 times more likely to have taken calcium channel blockers than the latter group. From this came the 60 percent increase in heart attacks with calcium channel blockers, which triggered the label "dangerous."

The newspaper article contains errors of fact, errors of implication, and errors of emphasis. The statement that calcium channel blockers "don't work very well" is at worst blatantly wrong and at best challengeable. The reference to national guidelines recommending beta blockers and diuretics is accurate, but its placement in the article implies that no other medications are recommended, particularly not calcium channel blockers. The emphasis on the danger of calcium channel blockers ignores the weaknesses of the study's design and immediately imputes cause to the relative risk of 1.6.

I had the misfortune of being on call the weekend this article hit the papers. Within hours, patients were calling to ask if they should stop taking these "dangerous" medications. (Hundreds of callers

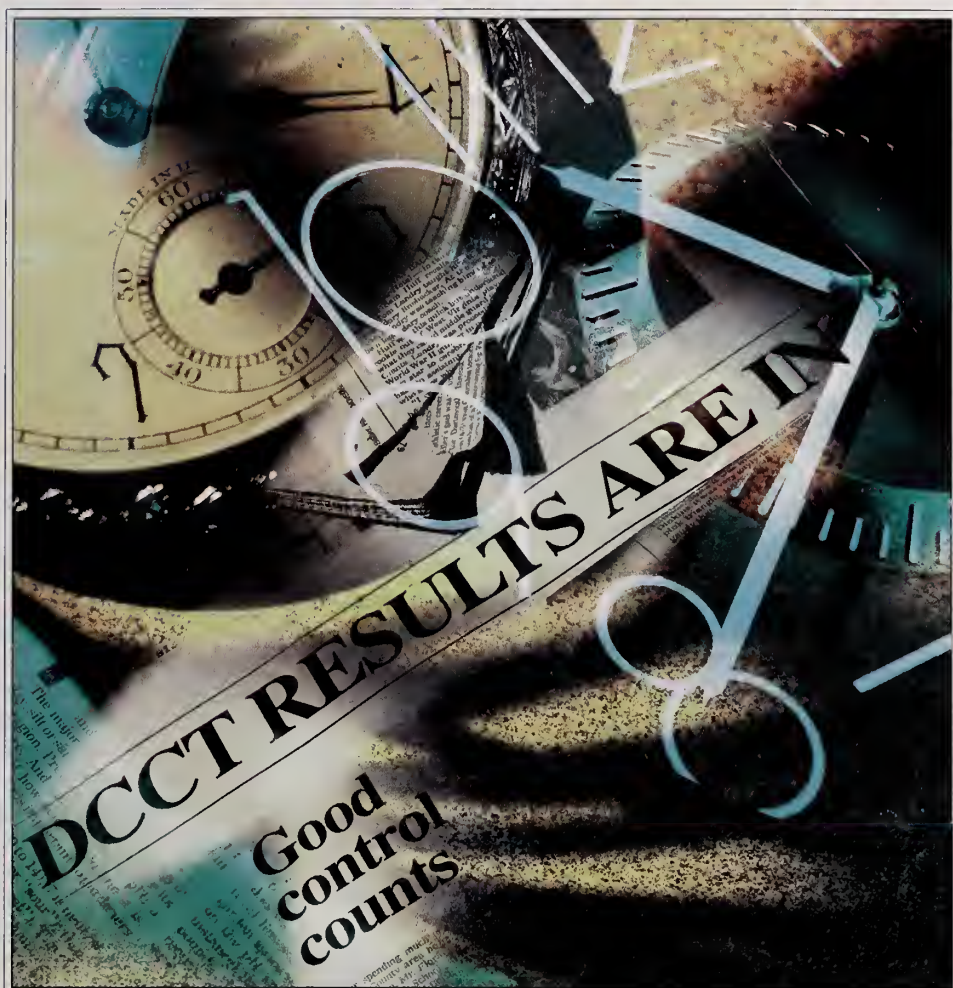
flooded the switchboards of the American Heart Association, the American College of Cardiology, and other health organizations.) When I described the structure of the study to patients who asked about it the following week, their response was, "Oh, is that all it was?"

What was the writer intending with this article and headline—to inform or to scare? Perhaps the problem lies in the writer's misunderstanding of case control studies. However, my patients rapidly grasped the weak link between relative risk and cause and effect. Perhaps the writer believed the study was too complex and had to be simplified. Yet, the topic was covered reasonably and cogently in the next day's *New York Times*. This headline read, "Heart Attacks May Have Tie to Drug Type." The lead paragraph said, "A new study suggests that people who take one type of high blood pressure medication may be more likely to have heart attacks." The article contained quotes from "experts" questioning this specific study, as well as the case control design.

New medical information deserves an objective airing by journalists who understand not only the implications of the medical knowledge, but also the scientific strength of the evidence. Newspapers should not serve as a vehicle for specious portrayals of ignorant doctors or rapacious drug companies conspiring against unwitting patients. The news is scary enough without invented dangers.

"Media Watch" is a new occasional column written by Minnesota Medicine's editor-in-chief, Charles R. Meyer, M.D. Watch page 2 in future issues.

When it's time for insulin...



Novolin®

Novolin®
Human Insulin
(recombinant DNA origin)
Choice, Control and Confidence



WARNING: ANY CHANGE IN INSULIN SHOULD BE MADE CAUTIOUSLY AND ONLY UNDER MEDICAL SUPERVISION.

Novolin Prefilled_® shown with NovoFine_® disposable needle attached. NovoFines_® sold separately. Novolin_®, NovoFine_®, and Novolin Prefilled_® are trademarks of Novo Nordisk A/S.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.

President-Elect
Michael J. Murray, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Ophelia Balcos

Board of Trustees

N. W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legal Affairs
Mary E. Prentnieks, J.D.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

Mindful of Capitation's Risks

Charles R. Meyer, M.D.

capitation: 1: a poll tax 2: fixed payment per person to provider of health care (derived from the Latin, caput).

caput: Latin for head.

caput morduum: in alchemy, the residuum left over after distilling, literally "dead head."

Capitation is turning heads. Though present for decades, capitation recently has rushed into public view with the rising pressures to cut health care spending. It promises great savings—a 15 percent to 60 percent drop in utilization compared with fee-for-service, a 15 percent to 40 percent drop in costs when introduced by some health plans. Yet it raises the hair on the heads of some providers because of the ethical, legal, and clinical tangles it weaves. Is capitation just another health reform headache, or will it help us get our heads together about costs and quality?

This month's *Minnesota Medicine* charges courageously into this debate, offering varied perspectives on capitation's potential—for good as well as harm. From issues more serpentine than a caput medusa, I have extracted the following thoughts:

1. Capitation has many heads. Payment can be fixed at many levels—health plan, hospital, doctor group, or a mix. Compensation to providers has many faces—from a prepaid budget with tracking of fee-for-service to pure capitation.

2. Whatever the arrangement, somebody's head is on the block. Capitation means risk sharing. Whoever shares the risk garners the rewards or faces the reaper. Payers like the federal government favor the idea of divvying up risk among plans or providers so HCFA budgeters can sleep soundly with their fixed pay-



"Capitation means risk sharing. Whoever shares the risk garners the rewards or faces the reaper."

ments. For those holding risk, money can be made, but financial decapitation is also possible.

3. Legal limits may impede headway toward workable systems. ERISA restricts who can share risk in health care delivery.

4. In many capitated plans, primary care emerges as head honcho. Guarding the fort against the barbarians of technology and superspecialized care, primary care gatekeepers in some systems are supposed to wisely dole out care. This is a role few practitioners were trained for and few eagerly seek.

5. Fiduciary responsibility means physicians are headmasters for their patients' care. However, the traditional "do everything for the patient" is being challenged by "do everything that makes sense for the patient and society." Advocates of the latter view claim outcome measurement and guidelines can allow docs to do this ethically. This attitude is not shared by all. A recent

ACP *Observer* article advocating that doctors maximize the health of the population evoked cries of "socialism" in letters to the editor.

6. In the end, what's most important is what goes on in the physician's head. What guides doctors' decisions when less utilization means more revenue? Can these decisions be separated from money in a capitated system? Many health care gurus claim salary is the compensation of the future because it isolates the doctor's pay from clinical decisions. But even if physicians are salaried, won't they think twice about ordering that MRI if their organization had a bad year and salary cuts are threatened? If organizations shift to looking at patient satisfaction and quality rather than productivity, will that encourage rational clinical decision making? Perhaps blended quality and financial incentives will build a clinically and ethically solid structure.

Capitation adherents criticize our present system of "do more, get more," and rail at greedy doctors for subjecting their patients to unnecessary procedures for financial gain. Yet any system so far proposed, including capitation, relies heavily on the good intentions of providers. And it will always be so. Only a profession based on science and empathy will ensure a balance between patient welfare and physician livelihood. Plato said physicians were "ruler(s) having the human body as a subject" and should rule for the good of that subject.

If we are to avoid a caput morduum health system, a worthless residue that nobody wants, we need to evaluate what we do while recognizing what it costs, see if it makes sense, and then explain it to our patients and society. In short, we need to use our heads.

MM

Higher Office to Higher Learning

Former U.S. Senator Dave Durenberger continues to shape health policy—not in the halls of Congress, but in the classroom, as an instructor and senior fellow at the University of St. Thomas.

The trappings of senatorial privilege are gone. His Minneapolis office is plain; his desk is standard-issue; he no longer has an entourage of aides. But make no mistake: Dave Durenberger is still a power in the politics of health care. In his post as senior fellow at the University of St. Thomas's National Institute of Health Policy, Durenberger is launching a new career as educator, moderator, and *éminence grise*. It is an untested role, but one he hopes will lend sanity and perspective to a debate that often seems more about turf than health care.

"All of health policy in Washington is now divided into little groups. Nobody is doing health policy. They're just doing 'protect your borders.' And that's very unhealthy for the future of health care," says Durenberger. "The one thing that I have is a vision of the future and a sense of the past and how we got there." At St. Thomas, he hopes to share that history and vision with physicians, health care administrators, and policymakers.

The Health Policy Institute, part of UST's Graduate School of Business, is still in the conceptual stage. Ultimately, say its creators, it will serve four roles related to health policy: convening local, regional, and national conferences; conducting applied research; producing publications; and serving as a resource center. "This institute is not going to be a building," says Durenberger. "It's really going to be a bringing together of people. What we're trying to do is empower the practitioners, whether it's in medicine or hospitals or business, because those are the people who deserve to be emulated and to be encouraged."

While helping to create the new institute, Durenberger is also teaching at UST's Center for Health and Medical Affairs. Last semester he taught a health policy course to a class of 19 students, including four physicians, who will receive master of business administration degrees in medical group management at the end of their three-year course of study. Durenberger's course didn't take the ivory tower approach. Stories from his years in Washington and frequent guest speakers provided lessons in *realpolitik* that students don't normally learn.

Introducing state epidemiologist Mike Osterholm as a guest speaker to his class, Durenberger related that when he once was trying to get a bill drafted in Washington, he paged Osterholm back in Minnesota. Osterholm, driving through southern Minnesota, stopped at a pay phone in the wee hours of the morning and helped Durenberger clarify sections of the bill.

"[Durenberger] gave sort of an insider's perspective of Washington and politics and how health policy happens," says Kathleen



"What we're trying to do is empower the practitioners, whether it's in medicine or hospitals or business."

—DAVE DURENBERGER

Senate. Indeed, he continues to consider Washington his home, and he recently joined a Washington-based consulting firm, APCO Associates, as senior counselor. APCO specializes in public affairs, public relations, and international business, and includes former U.S. ambas-

Brooks, M.D., a family physician in Crystal who took Durenberger's course. "And he did a good job."

Assessing his students, in turn, Durenberger says he finds teaching physicians health policy "more fun than arguing with them over health policy." In either case, he comes prepared; this professor truly does his homework. "We were taking [Durenberger's course] along with a health care economics class and a managed care course, and he tried to integrate those courses. He read our health care economics book and actually brought it in, with his highlighted sections in it," says Brooks. "Compared to many [teachers] we've had, I've been impressed."

While no one would dispute Durenberger's hard work, extensive experience, or detailed knowledge of health care issues, his appointment to the university post was not without controversy. In December 1994, a number of UST faculty protested his selection as senior fellow, noting that Durenberger was still under the cloud of felony charges related to alleged misuse of his Senate expense account.

Durenberger, who has denied the charges, is calm about the dispute. "I expected it to come," he says. "That's what faculties are for, they raise questions like that. And I think that's legitimate."

Durenberger's part-time position at UST is not his sole foray into health care policy after leaving the

sadors and members of Congress on its staff. Durenberger views APCO as a solid base from which to work on health care, environmental, and education issues.

In addition, Durenberger continues to travel widely to speak on health care issues. In recent months, he's spoken to physician and hospital associations and other groups in Florida, Arizona, New Hampshire, and Vermont. At these forums, at APCO, and at St. Thomas, Durenberger advocates the ideas he held so strongly while senator: that managed care is the best way to bring down spiraling health care costs; that single-payer doesn't work; that fee-for-service creates unhealthy incentives for unnecessary procedures; and that health reform should include national rules for local markets, empowerment of health care consumers through competition among providers, and medical liability reform.

Durenberger urges physicians to consider the role they must play in shaping their futures under health system reform, and the role he might play in helping them do so. "Physicians have to adjust to a new form of public policy," he observes. "They now have to figure out that they are all much better off living in a marketplace in which consumers are better informed

DURENBERGER continued on page 47

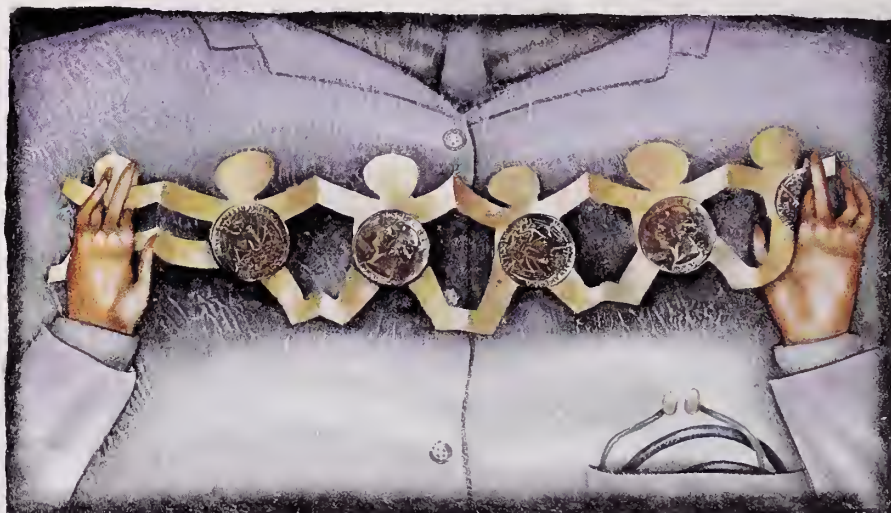


ILLUSTRATION BY ELIZABETH LADA

CAPITATION *without* TREPIDATION

Capitation arrangements can be both financially sound and professionally satisfying to the physicians involved, says this doctor, who knows from experience.

DAVID E. PAUTZ, M.D.

I ncreasingly, physicians and health plans in Minnesota and elsewhere are sizing up provider capitation agreements as a method of compensating physicians for their services while optimizing efficiency of patient care. I offer these reflections from the physician's point of view. My experience in practice with a large number of capitated patients began in 1983, when the provider staff of Share Health Plan, a Twin Cities staff model HMO, incorporated as a professional corporation, now known as Aspen Medical Group, and agreed to provide services to Share enrollees under a capitation agreement that still continues with Share's successor, Medica. Other capitation contracts have been added, and over the past decade the number of Aspen patients covered by capitation contracts has averaged about 50,000 per year, accounting for more than half of the patient visits to the group.

Under a capitation agreement, a medical group practice agrees to accept from the health insurance plan a predetermined, fixed amount of money per enrolled patient on a monthly basis in exchange for the provision of a specified set of health care services. The services covered under capitation may include all medically necessary services entitled to the enrollee under the insurance benefit contract or a subset of services. The physician or group may or may not deliver these services directly but is expected to provide for these services from the fixed capitation amount. Consequently, the group is accepting a financial risk rather than being paid a fee for each service. The premise is that the physician is in the best position to manage patient care services efficiently and will be rewarded for doing so. Conversely, a physician

who is inefficient or experiences adverse risk faces the possibility of financial loss.

Under the broadest capitation agreement, all medically necessary services are the medical group's responsibility, including all inpatient, outpatient, and emergency care, whether provided within or outside the service area; prescription drugs; medical supplies and durable medical equipment; mental health services; rehabilitation; and in some instances, nursing home room and board.

THE HEALTH PLAN PERSPECTIVE

From the health plan's standpoint, a capitated agreement is desirable because the insurance risk can substantially be passed on to the medical group, which is in the best position to manage patient care. Once the capitation amount has been fixed, that amount becomes the health plan budget for medical services, and the health plan only needs to budget its administrative expenses to determine the premium required to produce a profit. The health plan administrative expenses are lower because the medical group bears much of the cost of managing care. Many policing functions, such as pre-admission certification of medical necessity, can be eliminated because the medical group will develop its own systems.

THE MEDICAL GROUP PERSPECTIVE

For the medical group, a capitated arrangement may have several attractive features. First, by virtue of the prepayment feature, cash flow is improved and the cost of billing and collections is eliminated for those patients covered by capitation. Second, the hassle of justifying every procedure or admission to an insurance company reviewer is eliminated. Last, but most important, the physician is empowered to manage the patient's care in the most efficient manner possible based on quality and continuity. The physician is rewarded for efficient utilization, rather than punished, as so often happens under a fee-for-service payment mechanism.

A medical group's acceptance of a capitated payment arrangement necessitates a change in the method of physician compensation if the group is to succeed. The greatest challenge is to

define and measure physician productivity. In the usual fee-for-service arrangement, productivity equals production, that is, billing. Under a capitated agreement, increased encounters do not result in increased payment; rather, they add expense to the practice. To distribute revenue according to physician encounters under a capitated arrangement can lead to unproductive churning of patient visits.

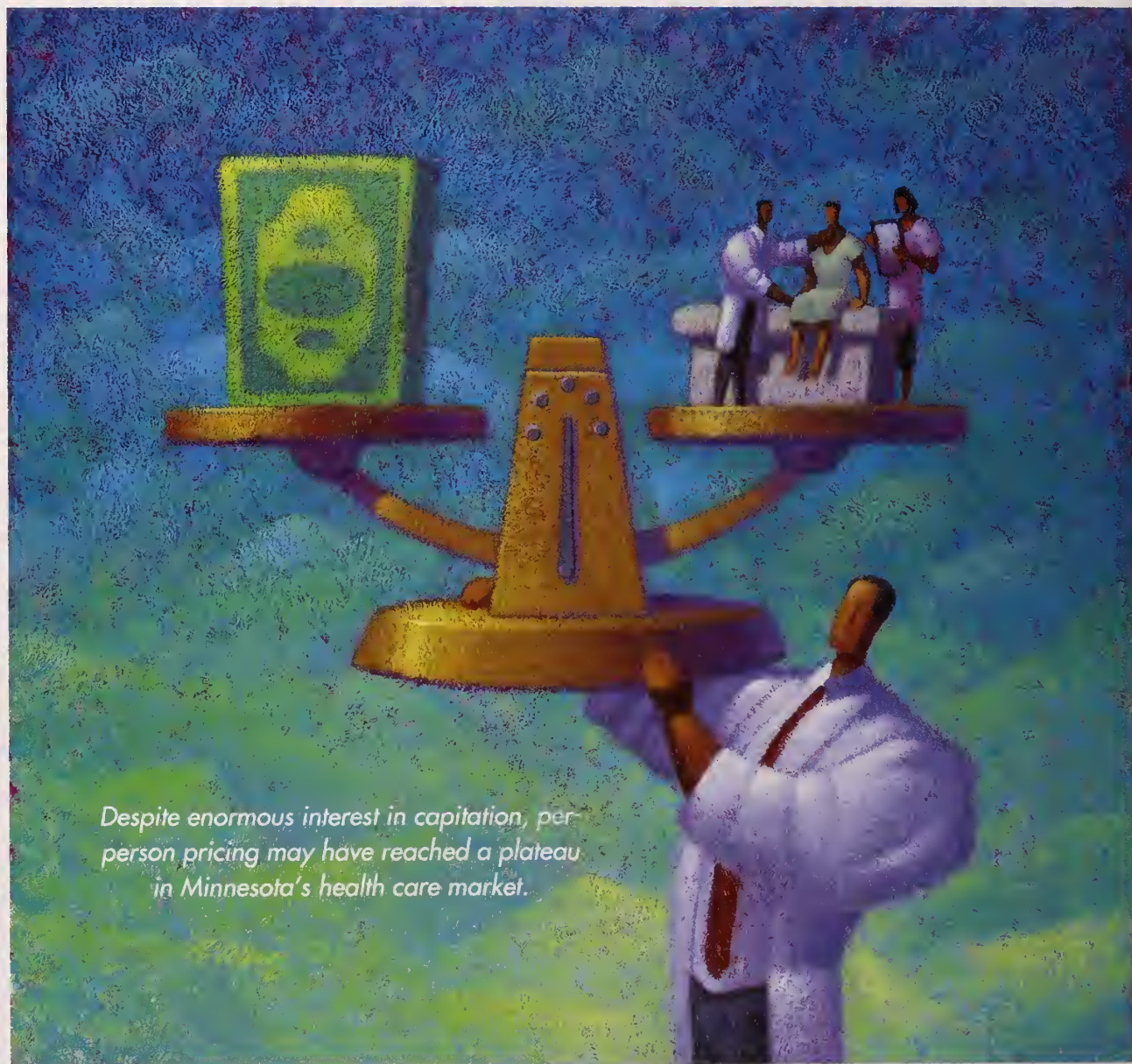
In Aspen Medical Group, physicians are paid a market-competitive base salary and may receive additional incentive compensation based on performance against certain targets, including successful operating results of the group as a whole; successful operating results of the clinic or department; and a subjective assessment of the physician's performance by a supervising physician, peer physicians, patients, and clinic staff. In no way is physician compensation linked to reducing expense by withholding necessary care to any patient. Physician practice characteristics are profiled by demographics of their patients, the number of encounters, utilization of ancillary services, cost of prescription drugs, number of referrals, and by hospital length of stay by diagnosis.

THE PHYSICIAN PERSPECTIVE

From the physician's perspective, practicing in a capitated group offers the opportunity to treat patients in the most rational and efficient manner. The physician and the group have a strong financial interest in assuring that the highest standards of preventive care are met. It is in the group's financial interest to diagnose and treat disease most expediently. In no way can a capitated group succeed financially over the long term from intentionally withholding necessary care. However, unnecessary ancillary tests and unnecessary medical practices that are not supported by the medical literature can be eliminated. The group can further increase productivity by replacing unnecessary office visits with telephone consultations, without the physicians feeling as if they are

CAPITATION continued on page 47

Doling Out Risk



How Capitation Measures Up in Minnesota

By Allan Baumgarten, J.D., M.A.

Let's start with a short quiz:

1. Capitation is:

- The unknown, scary monster under the bed.
- The best way for providers to retain professional autonomy and make money.

2. True or False?

Capitation is the wave of the future and is increasing in markets such as Minnesota.

Put your pencils down. First, some general definitions. Capitation is a payment arrangement by which a health care provider or provider organization accepts a fixed payment and agrees to make available specific health care services to a defined group of people. The payment is the same no matter how many times an enrollee visits the doctor's office or how many covered procedures are ordered. In effect,

not prescribe how an ISN will pay its participating providers; legislators and others *expected* that the use of capitation would increase in Minnesota and that the result would be vigorous competition by efficient, integrated care systems.

Capitation Surprisingly Limited in Minnesota

Given Minnesota's high managed care penetration, many people assume that the use of capitation is equally high. In fact, the best data available suggest that the use of capitation in Minnesota is limited and may, in fact, be declining.

First of all, state law generally restricts the use of capitation to arrangements between HMOs and providers (those legal limits are discussed later in this article). In 1993, about 26 percent of the state's residents were in insured plans in HMOs. Under current law, capitation is not an option for much more of the population, even those covered through other non-HMO managed care arrangements.

Second, even within the HMO market, capitation is not used that widely. The table (page 12) shows how much Minnesota HMOs paid to providers in capitation during 1993, the last year for which data are available, and what proportion their capitation payments were of total HMO medical and hospital spending. In 1993, HMOs spent \$1.7 billion for medical and hospital services. About 33 percent (\$567 million) was reportedly paid to providers through capitated arrangements. Medica paid only about one-fifth of its medical expenses under capitation arrangements, mostly provider contracts developed through the old Share HMO. The Physicians Health Plan part of Medica rarely used capitation, except for behavioral health services and hospital payments under the Medicaid program.

Disincentives limit capitation

One key reason for the limited use of capitation in Minnesota is the growing number of employers who self-fund their employees' health benefits plans. At the end of 1993, an estimated 1.2 million Minnesotans were in self-funded plans, in which the employer assumes the insurance risk for employees' medical care utilization. Under federal law, self-funded plans are not subject to state regulations, such as mandated benefits or most taxes and assessments.

While the law in this area is not crystal clear, it has

part of the financial risk is shifted to the provider.

Capitation is contrasted with fee-for-service arrangements, in which providers are paid for each unit of service delivered. In the purest form of fee-for-service medicine, the provider bears no financial risk and will be paid based on billed charges every time.

Tom Swain, chair of the Minnesota Health Care Commission, likes to describe the difference between fee-for-service and capitation payment arrangements this way: Under fee-for-service, a filled hospital bed is a source of revenue. If the hospital fills more beds, it earns more revenue. Under capitation, a filled hospital bed is a cost to the system.

Of course, nothing is simple, and the payment arrangements in use in Minnesota and other markets are much more complex. They form a continuum from pure fee-for-service payment to pure capitation, with a wide variety of contractual arrangements in between.

Advocates of capitation say that such arrangements are necessary to align the financial incentives facing provider, purchaser, and patient. When the architects of Minnesota's health system reforms developed their vision of competing integrated service networks, they described organizations bringing together physician and hospital care with care management and financing. Capitation—by making the financial incentives explicit—would be the glue holding those organizations together. Never mind that the MinnesotaCare laws do

been understood that if an employer shifted the insurance risk to providers through a capitation arrangement, then the employer was no longer self-funded. State regulators would argue that this arrangement quacked and waddled like insurance, so it must be insurance. In that case, the "protection" provided by self-insurance under federal law would no longer apply, and the employer would be subject to state regulations.

How has the issue played out? In 1993, MedCenters Health Plan, which merged in 1993 with Group Health to form HealthPartners, had the largest proportion of its medical costs in capitation payments. It paid

\$140.2 million in capitation in 1993 (including payments to dental providers), but that was down from \$149.5 million in 1992. The reason? In January 1993, about 35,000 MedCenters enrollees went from insured accounts, many in capitated arrangements with medical groups like Park Nicollet Medical Center, to self-funded plans. They were covered through companies in the Business Health Care Action Group (BHCAG), which began offering its Choice Plus plan then. Because Choice Plus was a self-funded arrangement, formerly capitated providers were now paid on a fee-for-service basis.

While the trend toward self-funding may be reducing the amount of capitation, creative plan administrators and employee benefits managers have devised arrangements in which providers share risk, but not to the point that might excite state regulators. Under these quasi-capitation or modified fee-for-service arrangements, payers shift some of the financial risk and the potential profit to providers, who are paid on an interim usual and customary fee schedule, subject to a withhold. At the end of the year, they will see more money returned depending on the overall performance of the plan and their individual performance. Some HMOs are also trying to incorporate HEDIS outcomes measures in determining how much to share with providers at year-end.

Another reason for the limited amount of capitation in this market is that HMOs are not rushing to develop such arrangements. A remarkable reversal has occurred in the past eight to 10 years. In the late 1980s, providers sought to avoid capitation arrangements, regarding them as unfair and unfavorable. Today's new generation of integrated physician-hospital delivery systems and clinics without walls have as their goal capturing as large a share of the premium dollar through capitation as is possible.

But, while provider networks are eager to accept capitation and are investing in the systems needed

1993 Minnesota HMO Capitation Payments

HMO	Capitation payments	Total medical-hospital expense	Percent
Blue Plus	\$39,207,636	\$82,521,559	47.5%
Central Minnesota Group Health	0	24,385,117	0.0%
First Plan	3,354,146	14,490,566	23.1%
Group Health*	204,301,000	450,153,000	45.4%
Mayo†	0	5,245,844	0.0%
MedCenters	140,194,492	280,051,700	50.1%
Medica	149,869,257	737,227,969	20.3%
Metropolitan	11,498,022	66,386,976	17.3%
NWNL Health Network‡	12,455,037	37,498,688	33.2%
UCare	5,907,874	42,515,072	13.9%
TOTAL	566,787,464	1,740,476,491	32.6%

* As much as \$156 million reflects payments for staff providers within Group Health.

† Mayo Health Plan reported no capitation arrangements, but its annual financial statement notes that it pays capitation to the Mayo Foundation for services provided to enrollees in its Medicare Supplement plan.

‡ Total medical/hospital expense calculated by adding reported commercial expenses and RamseyCare capitation amounts.

to manage capitation dollars, the HMOs recognize two profitable reasons not to expand their use of capitation. First, the potential to realize surplus on their operations comes from retaining the insurance risk, not shifting it to providers. Second, while utilization rates in Minnesota are considered low, HMOs recognize that there is still substantial fat in the system and that utilization will be driven down further. For example, while Minnesota's rate of inpatient hospital use for commercial HMO plans was 235 days per 1,000 enrollees in 1993, the comparable rate in Colorado was 207 days. Consultants suggest that the standard may soon be 175 inpatient days per 1,000 enrollees, a rate that some integrated (and mostly capitated) systems in California are now reportedly approaching. If an HMO negotiates a capitation contract with providers based on 1994 levels of utilization, then the providers, not the HMO, will profit as utilization rates go down in future years.

Not only does the HMO lose potential profits to its providers, but its competitors may also benefit. Dewayne E. Ullsperger, a principal at the actuarial consulting firm of Reden & Anders, points out that if one HMO is able to drive down utilization, other HMOs in that market will find ways to duplicate those results. If the competing HMOs don't capitate their providers, they enjoy the full benefit of reductions in utilization. This analysis applies especially to HMOs entering markets where average rates of inpatient utilization are 350 days per 1,000 enrollees and higher.

Subcapitation spreads risk to specialists

Of course, not all providers are equally eager to capitate. Gary Van House, administrator of Columbia Park Medical Group and Physicians Service Network, suggests that many physicians fear what he calls "the monsters under the bed." They are nervous about capitating for services they think are outside their control. For example, they worry about adverse selection in their patient pool, separate providers for mental health and chemical dependency treatment, and out-of-network utilization by patients.

Given the choice, some of these doctors would only agree to capitation arrangements in which their risk is limited to the services they provide. Van House advises them that most of the potential for cost control is outside

of primary care. By limiting their risk, these doctors forgo most of the profit potential.

Some medical groups have developed subcapitation arrangements, that is, they share part of their capitation and financial risk with other providers. Van House says he is especially pleased with the subcapitation arrangements that Columbia Park has developed with hospitals and with certain specialty groups. These arrangements require the groups to work closely together, and they yield better care and a better understanding of what works.

Columbia Park, which was part of the old Share network, has seen a reduction in the portion of its business that is capitated. In the late 1980s, more than 60 percent of the group's business was capitated,

but that has declined to about 40 percent today as employer groups switched to self-funded and point-of-service plans.

Despite that decline, some people expect capitation to increase in this market as purchasers assume a more direct role in contracting with providers. Brad Miller, vice president of marketing for Minneapolis Heart Institute, expects purchasing coalitions to develop capitated arrangements with primary care groups, who will in turn subcapitate with specialists. In anticipation of that change, Minneapolis Heart Institute is working with one of its largest payers to provide eight to 10 of the most frequent cardiology procedures on a packaged price basis. While payment will still be sensitive to volume, Miller views the change as a step toward specialists assuming more risk.



Capitation Leading Groups to Align Incentives

Picture a hospital executive guiding you through her hospital saying, "Here are the beds where we make money if we keep them empty. And over here are the beds where we make money if they are filled." Groups like Columbia Park and HealthSystem Minnesota (HSM), the parent company of Park Nicollet Medical Center and Methodist Hospital, face the conflicting incentives of organizations that are partly capitation and partly fee-for-service. James Reinertsen, M.D., president of HealthSystem Minnesota, says that such a mixture of financial incentives cannot be applied at the physician level—it would be ethically difficult as well as impractical to treat

HOW DOES CAPITATION WORK?

A hypothetical Minnesota health maintenance organization collects an average of \$115 per member per month in premium revenue for enrollees in a commercial HMO plan. It has negotiated a contract with a group of 90 primary care doctors to pay them a fixed fee each month for every enrollee that selects that group.

The capitation amount in this hypothetical case will cover not only primary care provided by the medical group but also payment for specialist referrals and hospital admissions. The medical group's risk is limited by contract provisions that allow for supplemental payments if a hospital stay goes beyond a certain threshold and by using stop-loss coverage. In some cases, the HMO may also sell the stop-loss coverage through an affiliate.

The exact amount of the payment is adjusted based on demographic data—the age and sex of the enrollee. Plans may also make adjustments for health status or conditions or to reflect the terms of the stop-loss arrangements in place. In this case, the average payment may be \$85, with the HMO retaining the rest for administration, surplus, and certain services for which it may still retain risk, such as out-of-area coverage.

HMOs often divide the capitated payments into separate risk pools for primary care, specialty care, hospital stays, and pharmacy. These risk pools can be thought of as separate checking accounts to pay for services. Depending on the size and sophistication of the medical group practice, the HMO might manage the “checkbook” for specialty referrals and hospital admissions, or the medical group might administer those funds itself.

patients differently based on their payment arrangement. Instead, HSM has chosen to pay physicians a salary, an arrangement in which they don't make more by doing more for the fee-for-service patient or less for the capitated one. It is left up to the larger organization to resolve the mixed incentives.

Reinertsen is a firm proponent of capitation as a means of aligning incentives. To illustrate, he describes how HSM began to implement its first new treatment protocol, for diagnosing and treating urinary tract infections in women. The BHCAG members want more consistency in the way care is delivered across the entire provider system, and they are working with HealthPart-

ners and HSM to develop 80 practice protocols over the next few years.

The first new protocol cut out some of the office visits and lab work that had traditionally been used to diagnose and treat urinary tract infections. It has led to higher patient satisfaction, better medical results, and a reduction in HSM's billings of \$250,000. If this experience repeats itself with each of the next 79 protocols, Reinertsen muses, then HSM will have the highest quality and lowest cost, and it will be the most bankrupt integrated system. The moral of the story is that a provider group should not be penalized for finding ways to improve the quality of care while reducing costs at the same time.

Legal Obstacles Discourage Capitation

Reinertsen says that when the Minnesota health care market passes 50 percent capitation, it will be a watershed event, because all providers will see the need to manage expenses and care rather than trying to maximize revenue. But that won't happen unless the legal obstacles that discourage capitation by self-funded employer groups are removed. For that reason, HealthPartners and HealthSystem Minnesota jointly approached legislators last spring with a proposal that would open the door to such arrangements.

The result was a compromise that attracted a good deal of interest from health lawyers and others, but apparently not enough from the employers themselves. The Legislature agreed that capitation amounts paid by a self-funded employer to an HMO (or other licensed insurer or network) would not be regarded as insurance premiums for certain purposes, but would be considered insurance premiums for other purposes. Confused? Here's the language the Legislature adopted:

An organization licensed as a health maintenance organization that accepts payments for health care services on a capitated basis, or under another similar risk sharing agreement, from a program of self-insurance ... shall not be regulated as a health maintenance organiza-

tion with respect to the receipt of the payments. The payments are not premium revenues for the purpose of calculating the health maintenance organization's liability for otherwise applicable state taxes, or surcharges, with the exception of:

- 1) the MinnesotaCare provider tax;
- 2) the one percent premium tax ...
- 3) ... assessments by the Minnesota Comprehensive Health Association (Minn. Stat. § 62D.02, subd. 4).

The law goes on to limit this option to employers with at least 750 employees and to require that self-funded employers paying capitation participate in state data collection and administrative simplification initiatives.

Although this provision was passed with the Business Health Care Action Group specifically in mind, the BHCAG companies were not impressed with the extra costs or the limited flexibility offered. BHCAG is not using the provision to capitate Choice Plus providers, nor apparently are any other large employers. The BHCAG members are benefiting now from relatively low cost increases; they may be more interested in capitation options if a new cycle of increasing health care

costs begins. Bills now under consideration in the Minnesota Legislature would open the door wider to capitation.

Any Way You Slice It ...

Capitation has generated enormous interest. Actuaries are in high demand, managed care companies offer new administrative services to provider groups, and a new industry has sprung up for publications and seminars advising organizations how to profit from capitating. Yet while provider groups here have built their competitive strategies around accepting capitation, maybe they're just pursuing pieces of a shrinking health care pie.

The great philosopher and baseball catcher Yogi Berra ordered a pizza pie and was asked: "Do you want it sliced eight ways or four?" "Better make it four," he said. "I don't think I could eat eight slices." **MM**

Allan Baumgarten is a consultant on health care policy, finance, and local market strategies and the author of Minnesota Managed Care Review, an annual report analyzing key trends and issues in the Minnesota health care market.

Must reading for all physicians!

"Reading Dr. Faria's passionate plea is guaranteed to galvanize you to action."

**— Jane H. Ingraham,
The New American**

Miguel A. Faria, Jr., M.D. provides compelling arguments that answers to the dilemma of health care reform reside on the pages of history. This fascinating book draws parallels between the past and the present, from a time when the fine line separating myth and history was blurred and indistinguishable to the clearly troubled present.

Order direct
\$41.95

Add \$3 for shipping and handling

Call

1-800-757-9873

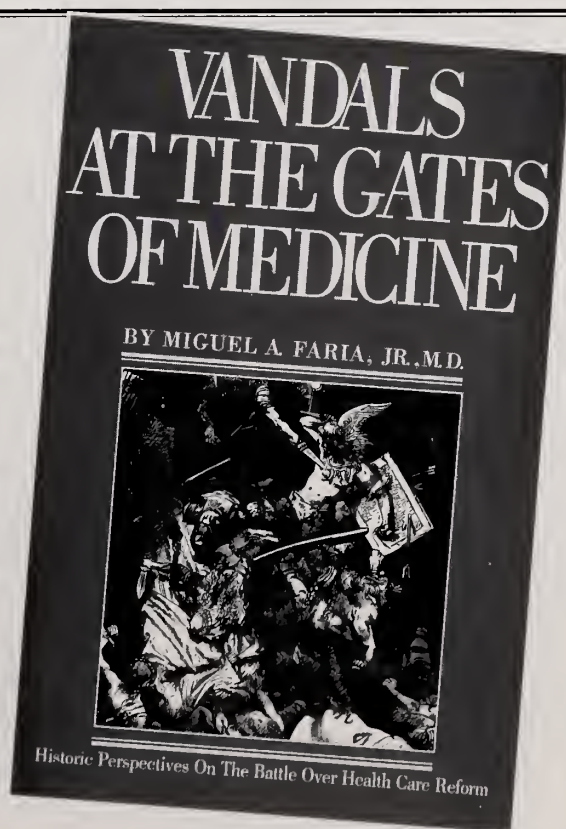


Hacienda Publishing

Fax: 1-912-757-9725 • P.O. Box 13648 • Macon, GA • 31208-3648

ISBN Number 0-9641077-0-8

Also Available at
fine book
stores everywhere



Is Capitation Right for Your Practice?

Understanding the insurance risk, negotiating a fair contract, and controlling utilization are key to successful capitation.

Capitation. Is it for your organization? The answer depends on whether your group can appreciate the inherent insurance risk, negotiate a satisfactory contract, and control utilization. Capitation contracts that deliver value require integration of clinical and actuarial issues in planning, contracting, and execution. Poorly conceived capitation contracts can result in unsatisfactory care for patients, financial loss and the provision of unanticipated care by providers, and lost enrollment for health plans. This article addresses capitation from the physician's viewpoint, focusing on the financial and actuarial considerations.

Principles of Capitation

Capitation is a method by which providers price health care services. Unlike fee-for-service, discounted fee-for-service, and various contracted prices, capitation reimburses providers for the delivery of a specified set of services for a specified population for a specified period of time. The fixed payment is typically quoted at "per-member-per-month." Unlike fee-for-service and contracted reimbursement, capitation incorporates insurance risk.

Capitation is not synonymous with managed care. The latter implies a broader scope of methods to control medical costs, only one of which is reimbursement. However, managed care's comprehensive range of services, tight linkage between health plans and providers,



integrated information and administrative systems, closed provider panels, and captive patient populations lend themselves to capitation. Today, health plans frequently reimburse through capitation, ranging from 46 percent of staff model plans to 97 percent of mixed plans.¹ In recent years, capitation has expanded to specialists. A 1991 American College of Cardiology survey found that approximately 12 percent of its mem-

bers participated in capitation. According to Joshua Seidman of the ACC, current statistics suggest a doubling of this proportion. The extension of capitated reimbursement beyond fully integrated delivery systems brings new challenges involving the transfer of insurance risk and clinical and financial responsibilities.

Why do health plans choose capitation? First of all, physicians determine health care spending. Health plans seek to use incentives that will incorporate economic considerations into clinical decisions. A second advantage for health plans is that capitation transfers some of the insurance risk to physicians, which allows the health plan to more accurately plan its budget. While assuming more risk, the physicians also share in the potential cost savings and profit.

What are the implications for capitated providers? Most physicians realize that successful capitation implies controlling utilization. Perhaps less well appreciated are the implications of insurance risk. Two fundamental principles of insurance are most relevant. First, the

By Randall S. Vollertsen, M.D., M.B.A.,
and Robert B. Cumming, F.S.A., M.A.A.A.

relative insurance risk, expressed as a percentage of the total capitation revenue, decreases as the number of potential clinical events increases and the variation in the claims associated with different events decreases. Therefore, the more covered lives, the more expected clinical events, and the more homogenous the clinical events, the lower the relative risk. (Of course, the likelihood of experiencing a given claim increases as the number of clinical events increases. Thus, although a group may have a lower relative risk of losing 10 percent of the capitation pool with more lives, the likelihood of losing a fixed amount, for example \$50,000, increases.) The second insurance principle is the concept of selection. Differences in the marketing, benefits, and underwriting of health plans attract different segments of the population that may have different health risks. A health insurer, including a physician who accepts capitation, may sustain unexpected financial loss if adverse selection occurs.

Capitated providers need to remember that even with sufficient members and accurate actuarial projections, there will be fluctuation around a mean from period to period. Fewer members, wider variation in the cost and frequency of events, and shorter time periods result in wider fluctuation about the expected mean.

Capitated physician groups can reduce financially unacceptable variation through reinsurance, often called stop-loss coverage, which limits their maximum loss. Of course, reinsurance is not free, and selecting the optimal level is part of the contracting process.

Why should providers choose capitation? First, they may believe they can outperform the current marketplace in controlling utilization and thereby reap a reward for accepting insurance risk. Second, they may welcome the regular cash flow. Capitation payments are typically paid on a regular schedule before services are rendered. Third, physicians may accept a capitation offer in order to increase or preserve market share.

Basic Considerations

In evaluating a capitation proposal, physicians need to consider numerous basic questions, specifically, who, what, when, where, and how.

WHO ARE THE INVOLVED PARTIES? They include three groups—providers, the health plan, and the prospective patients. Provider organizations encompass fully integrated health

care delivery systems, multispecialty group practices, primary care networks, and various carve-outs, such as mental health, pharmacy, or subspecialty services. Providers who are considering capitation need to carefully determine which services they will provide. Advance planning of clinical delivery is the first step in evaluating a capitation contract.

Providers also need to evaluate the reputation, financial viability, and marketing clout of the prospective health plan. Can the plan deliver? Finally, providers should assess the demographics of the prospective members. Total use of medical services varies widely with age, gender, geographic area, lifestyle, occupation, and other factors. For example, a 62-year-old man will require five times as much health care as a 22-year-old man. A person living in a Coastal state may make approximately 30 percent more medical office visits than a person living in a Midwestern state.²

"The extension of capitated reimbursement beyond fully integrated delivery systems brings new challenges involving the transfer of insurance risk and clinical and financial responsibilities."

WHAT IS THE NATURE OF THE PROPOSED CONTRACT? What does the plan expect the providers to cover? Outpatient care, hospital care, and ancillary services are broad categories. Detail to the level of CPT-4 codes is generally advisable, particularly when specialists are contracted for specific services. What will the plan provide? For example, the contract should require the plan to provide financial records and operational reports. Responsibilities for the verification of coverage, coordination of benefits, collection of copayments, and arrangements for reinsurance should be spelled out.

WHEN WILL THE CONTRACT TAKE EFFECT? This has dimensions beyond the term of coverage. Actuarial projections are necessarily based on historical data, and contracts extend into the future. Between the collection of the actuarial data and the termination of the contract, inflation, technological changes, and fluctuations in number and the demographic composition of enrollment may require contract adjustments. For example, an increase in the median age of the membership could affect operational and financial aspects of cardiology services. Another dimension of the plan's timing involves incurred-but-not-reimbursed, or IBNR, services. Because claim submission and payment lag behind service delivery, a capitated group that subcontracts with other providers on a fee-for-service basis must account for any outstanding unpaid fees at the end of each period.

WHERE WILL SERVICES BE PROVIDED? In addition to the straightforward issue of geographic location and hours of operation, responsibilities for out-of-network services must be considered. Who is financially responsible for emergency services provided outside the primary network and for care when patients are away from home? Point-of-service plans require special clarification in this regard.

HOW WILL THE SYSTEM WORK? The initial capitation agreement, its operational implementation, and the provider's internal compensation plan are important. Is the capitation rate realistic? As noted, costs vary widely among demographic segments within the community and among different geographic areas. Thus, relying on a simple, uninformed survey of the market before accepting a capitation rate is risky. The health plan will certainly obtain professional input in calculating its offer, and providers are advised to do the same before signing an agreement.

How to successfully implement the capitation agreement is the next aspect of the *how* question. What do other providers achieve and how do they do it? How can the provider group achieve the required level of efficiency? These operational questions require integration with clinical management, not only within individual groups but within the health plan's entire delivery system.

Determining how the proceeds of capitation are to be divided among capitated providers is perhaps the most difficult aspect of organizing the system. Some groups distribute capitation directly, either pro-rata or based on the actual membership of individual panels. The former variant overlooks the contribution of physicians who attract a larger complement of patients or tend to accumulate more challenging patients with a longer duration of practice. The latter variant requires increased, often cumbersome, bureaucratic surveillance. In many groups, individual providers are not capitated. Early systems often relied on salary, typically adjusted for the specialty and seniority. This can lead to motivational problems in some groups and usually requires some bureaucratic supervision in the form of patient quotas or mandated hours. A third alternative is to distribute capitation proceeds based on productivity. One potential problem with this method is misaligned incentives. Although the capitation plan as a whole is designed to encourage reduced utilization, individual providers are rewarded for increased utilization.

Many health plans and provider groups use withholds or bonuses. Withholds are portions of reimbursement that are not distributed until specified outcomes are

achieved. Withholds and bonuses may reward clinical, service, or financial outcomes that are desired either by the health plan or the provider group.

The problems associated with determining compensation multiply when—because of history, location, specialty, separate capitation agreements, or other factors—providers within the same health plan feel they are in different groups. No method is “right.” Each has advantages and disadvantages, and each may work in the right situation. Each group should determine a reimbursement structure that will work best for its physicians. Deciding on a reimbursement structure before entering the contract is advisable since prospective opinions tend to be less biased than retrospective opinions. A third party may facilitate compensation decisions.

Considerations for Different Practice Settings

Integrated delivery system

The classic fully integrated delivery system internally provides all medical services. A clinical consensus, established lines of referral, an integrated information system, accepted administrative rules, and a predetermined income distribution among providers facilitate acceptance of capitated reimbursement.

Primary care network

Compared with a fully integrated delivery system, a network of primary care providers presents more complicated challenges in undertaking capitation.

The exclusion of specialty care from the agreement means that more care occurs out of the network. The contract must specify which services the primary care network will deliver and which services other providers will deliver. It must delineate responsibility for inpatient care, specialty care, ancillary services, and other services. Inpatient services are the most expensive and perhaps controllable portion of care.³⁻⁸ In an unmanaged commercial population, claims related to hospitalization make up approximately one-third of the total.² Ancillary services have driven much of the inflation in inpatient charges.⁹ Evidence suggests that capitation reduces ancillary testing.^{8,10,11} Primary care networks are frequently held responsible for a portion of the inpatient, specialty, and ancillary services through separate risk pools that represent portions of the total capitation and that are budgeted for different segments of care. Any surplus or deficit in individual pools is shared between the health plan and the network.

Thus, a primary care network may accept additional

insurance risk over which it has less direct control. There is strong motivation to keep as much care as possible within the group and to carefully scrutinize any care transferred to other segments of the delivery system. On one hand, primary care clinical events tend to be more homogenous than those that occur in secondary and tertiary care, which reduces the primary care portion of insurance risk. On the other hand, in comparison with a fully integrated system, the events for which the primary care physicians are responsible are fewer. The same is true for each of the other risk pools. This may increase the relative insurance risk within each pool. The last two effects become more significant as the primary care network becomes smaller. Adverse selection is more likely in such networks. Increased risks may be offset—at a cost—with relatively more reinsurance than that required for an integrated system.

Specialty group

Specialty groups are typically smaller than primary care networks, reflecting the need for fewer specialty services. For example, a population typically requires one orthopedic surgeon for every eight to 10 family practitioners.¹² Specialty services tend to be more expensive and, in many cases, have more variance among claims than primary care services. Identical health problems may be served by specialists and by nonspecialists, underscoring the importance of defining who will provide which services. One-third of patients obtain the majority of their care, including screening, from specialists.¹³ Conversely, approximately 60 percent of cardiovascular studies are obtained by noncardiovascular specialists.² Different reimbursement arrangements can drastically alter referral criteria and workloads. Depending on the interplay of incentives within the delivery system, capitated specialists may handle either more or fewer complicated, time-consuming cases. In comparison with primary care, specialists are more likely to offer services that are subject to expensive technological change, a factor that can complicate actuarial trend projections. All of these factors increase the insurance risk for a capitated specialty group in comparison with capitated integrated delivery systems and primary care networks.

Clearly delineating which provider is clinically and financially responsible for care under what circum-

stances is paramount. Incentives for specialty referral are likely to be quite different for a capitated primary care network that shares in a referral risk pool and subcontracts with noncapitated specialists than for a capitated primary care group that participates in a health plan using separately capitated specialists with whom it does not share referral risk. As an illustration, suppose that a capitated orthopedic surgeon and a capitated primary care physician disagree about the necessity for cardiovascular consultation for a patient who has just undergone a total hip replacement. Furthermore, suppose the orthopedist is capitated only for professional services while the primary care physician participates in inpatient and ancillary service risk pools. One can foresee the potential for clinical and financial conflicts. Out-of-network services may be more problematic with specialty than with nonspecialty capitation since there

are fewer providers in a geographic region.

Conclusion

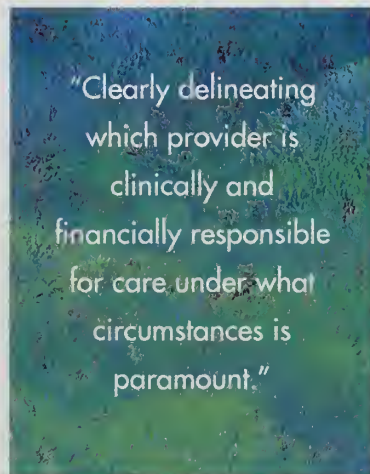
Should your organization elect capitation? The answer will depend on the answers to three other questions. Does your organization understand the inherent insurance risk? Can your organization negotiate a fair contract? Will your organization be able to control utilization? Organizations that undertake capitation without understanding the risks, negotiating a satisfactory contract, or delivering the goods may fail. Such failure may cost money and morale.

MM

Randall Vollertsen is a rheumatologist who practiced for 14 years at the Mayo Clinic in Rochester. Last year he joined the Minneapolis office of Milliman & Robertson, the largest actuarial health care consulting firm in the nation, where he assists physicians, health plans, and hospitals in developing health care delivery networks. Robert Cumming has been a consultant with Milliman & Robertson since 1988. He is a fellow in the Society of Actuaries and a member of the American Academy of Actuaries. He works on the actuarial aspects of developing physician-hospital organizations, and he has extensive experience with health plans.

REFERENCES

1. The InterStudy competitive edge; vol. 1; no. 2. Bloomington,



- Minnesota: InterStudy Publications, Inc., 1992.
2. Milliman & Robertson, Inc. Health cost guidelines. Bloomington, Minnesota: Milliman & Robertson, Inc., 1994.
3. Hillman AL, Pauly MV, Kerstein JJ. How do financial incentives affect physicians' clinical decisions and the financial performance of health maintenance organizations? *N Engl J Med* 1989;321:86-92.
4. Robinson JC. HMO market penetration and hospital cost inflation in California. *JAMA* 1991;266:2719-23.
5. Manning WG, Leibowitz A, Goldberg GA, Rogers WH, Newhouse JP. A controlled trial of the effect of a prepaid group practice on the use of services. *N Engl J Med* 1984;310:1505-10.
6. Luft HS. How do health-maintenance organizations achieve their "savings"? Rhetoric and evidence. *N Engl J Med* 1978;298:1336-43.
7. Luft HS. Health maintenance organizations: dimensions of performance. New Brunswick: Transaction Books, 1987.
8. Miller RH, Luft HS. Managed care plan performance since 1980: a literature analysis. *JAMA* 1994;271:1512-9.
9. Showstack JA, Stone MH, Schroeder SA. The role of changing clinical practices in the rising costs of hospital care. *N Engl J Med* 1985;313:1201-7.
10. Epstein AM, Begg CB, McNeil BJ. The use of ambulatory testing in prepaid and fee-for-service group practices: relation of perceived profitability. *N Engl J Med* 1986;314:1089-94.
11. Hlatky MA, Lee KL, Botvink EH, Brundage BH. Diagnostic test use in different practice settings: a controlled comparison. *Arch Intern Med* 1983;143:1886-9.
12. Kronick R, Goodman DC, and Wennberg J. The marketplace in health care reform: the demographic limitations of managed competition. *N Engl J Med* 1993;328:148-52.
13. Spiegel JS, Rubenstein LV, Scott B, Brook R. Who is the primary physician? *N Engl J Med* 1983;308:1208-12.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.



Call Central Minnesota Group Health Plan today and put time on your side.

Central Minnesota Group Health Plan

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

At many hospitals, physicians battle every day with things invisible to the naked eye.

At North Memorial, we think you should spend less time worrying about your career and more time worrying about your patients. That's why we believe in policies that are also beneficial to Internal Medicine and Family Practice Physicians. If you'd like to practice in a truly innovative medical community in Minneapolis or a surrounding suburb, call a Physician Placement Coordinator at 1-800-275-4790.

Such as hospital policies.



When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

To apply, call:

612-623-2860 or

toll free 1-800-298-MMBR (6627)

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

Disability income insurance that pays benefits. Come illness, injury or good health.

Protect the earnings you work
so hard for with our Preferred
Professional policy:



- Non-cancellable
- Guaranteed to age 65
- Pays benefits for total and partial disability
- Automatic coverage increases can be built in.



And our optional premium refund benefit
will return to you up to one-year's or
three-year's premium payments every fifth
year if you're fortunate enough to stay
healthy!*

Contact us today for a complimentary,
no-obligation disability needs analysis.



*One dollar is subtracted from your refund for every dollar in claims benefits received in the previous five years.

Minnesota Physicians Insurance Agency

3433 Broadway St., NE

Suite 375

Minneapolis, MN 55413

Tel: (612) 623-2860

Fax: (612) 623-2855

The Paul Revere Life
Insurance Company



Join Paul Revere, and ride with the winner.

Who Bears the Risk When Physicians Are Also Insurers?

The new world of capitation and risk sharing could compromise the physician-patient relationship.

Gordon J. Apple, J.D.

The role of physicians is being redefined in a debate over the future of health care that has profound implications for the physician-patient relationship. In an era of intense reform and in a state known for its health care gurus and prophets, Minnesota physicians are constantly reminded that they are on the forefront of redefining medical practice to meet the new realities of the marketplace. Terms such as utilization review, report cards, risk sharing, and capitation are part of the new lexicon. Unfortunately, the patient sometimes seems lost in the confusing shuffle. Where physician and patient interact in the office, clinic, or hospital, important questions have arisen with few definite answers.

- Where is the physician-patient relationship headed?
- What will remain of the fiduciary ethic, which requires allegiance to patients and forms the historical foundation of the physician-patient relationship?
- Is "fiduciary ethic" an outdated concept in the era of capitation?

To help answer these questions, this article considers the role of physicians as insurers; defines physicians' traditional fiduciary duty to the patient; discusses the conflicts that develop when patients become capitated units with outcomes, hopefully not adverse; and describes efforts to formulate guidelines addressing the ethical dilemmas arising in today's medical marketplace—a health system under reform.

Physicians As Insurers

The word capitation means different things to different people, but the insurance concept behind the word is risk transfer. Under capitated health care, physicians share in the risk that an insured population of patients can be cared for at a cost less than the premium charged. By contracting with physicians under capitated agreements, third parties seek to transfer a portion or perhaps all of the risk associated with being wrong about the projected cost of caring for an insured population.

Whether the payer is a private insurance company, HMO, integrated service network (ISN), or the government, it generally prefers capitated agreements to fee-for-service agreements because its costs are fixed and it can more easily manage its administrative overhead. As any good insurer knows, when it passes on or transfers the risk of loss, or spreads it through stop-loss or reinsurance arrangements, its margin of uncertainty decreases. Less uncertainty means the insurer or payer can profitably compete for greater market share, or in the case of private companies or the government, manage budgets.

The fact is, physicians are entering the insurance business through risk-sharing agreements; while some participate willingly, others must be wooed, cajoled, or dragged into these new arrangements. Some physicians will thrive in this new environment, and others will flutter around like

trout caught in a recently dammed stream. Numerous questions are raised by the change in paradigms. How can physicians outside of large group practices (either the real or simulated type, such as clinics without walls) achieve the economies of scale to share the risk of capitation? How can physicians competently analyze the data to determine if they can afford to share the risk? Finally, and most importantly, what becomes of the physician-patient relationship in the world of capitation, risk transfer, and insurance? At what level of capitation is physicians' fiduciary duty to place their patients' interests above all others weakened or ethically compromised?

The Fiduciary Ethic

Risk transfer, cost containment, and third-party involvement through utilization review and alleged "cook-book medicine" guidelines have raised concerns that physicians' "fiduciary ethic"—the need to put patients' interests above their own—may be ending. As Bradford Gray notes in his book "The Profit Motive and Patient Care,"¹ physicians' fiduciary ethic derives from their powerful influence over their patients. "The vulnerability of patients and the wide disparity in knowledge that commonly exists between doctor and patient create tremendous potential for exploitation and mistrust. In response, ethical and legal norms and expectations have developed that define the doctor's first responsibility as to act

in the interests of the patient. ... Terms such as agent, advocate, trustee, and fiduciary are often used to describe the physician's responsibilities to the patient."¹ Tom Beauchamp and James Childress in their book "Principles of Biomedical Ethics," discuss the "rules of fidelity" in outlining the same concept.²

Conflicts of Interest

The physician's role as a fiduciary with the corresponding duty of fidelity to the interests of the patient has potential for conflict for a number of reasons. Significantly, the goal of cost containment in the context of managed care is generally shared by only two of the three parties in the health care equation. The first party, the insurers or payers, share the goal because they want to control escalating costs and perhaps even lower them to generate revenues. The providers share the goal because they understand it is the new reality, they

want to survive in an increasingly competitive market, and they know something about the concept of limited resources and want to generate revenues. Assuming the provider has entered into a risk-sharing capitation arrangement so that success or failure to meet cost-containment goals has very real economic consequences, the provider then has a "financial incentive" to provide just the right amount of care. Patients, however, generally do not share the goal of cost containment in the context of their own health care. Unless more care is somehow harmful, most people want as much care as they can possibly get, and if their life or that of a dependent is on the line, they generally feel entitled to any chance for health that medicine can provide, even a slim chance.

Patients bristle when they are reduced to a mere number, perceived as a unit, told they cannot have something they feel they need, or worse

yet, told that they are not allowed to do something. Perhaps this explains some of the tensions that have emerged in health care as physicians and their patients come to grips with a fast-changing health system.

E. Havvi Morreim, in her book "Balancing Act—The New Medical Ethics of Medicine's New Economics,"³ states that physicians should adjust to the new reality, which is not so bad as far as resource allocation models go. Morreim recognizes, however, that the "financial reorganization of health care does not come already equipped with its own moral analysis." In reviewing "challenges to fidelity," Morreim states that physicians must merit a patient's trust in two ways: first, through professional competence, and second, by being dedicated to patients' interests first within the restraints of the new economic reality.

It is this dedication that seems in jeopardy when physicians are work-

Ethical Issues in Managed Care: AMA Recommendations

The American Medical Association's Council on Ethical and Judicial Affairs has adopted the following guidelines addressing potential conflicts of interest physicians may encounter under managed care arrangements:

1. The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.

2. When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

- (a) Any broad allocation guidelines that restrict care and choices—which go beyond the cost/benefit judgments made by physicians as a part of their normal professional responsibilities—should be established at a policymaking level so that individual physicians are not asked to engage in ad hoc bedside rationing.

- (b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

- (c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical

staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

- (d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policymaking level to seek an elimination or modification of the guideline.

Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the

ing in the new era of managed care. Amy N. Bossen, M.D., in a letter to the *New York Times*, expresses anger and frustration over trying to reconcile the conflicting roles of physician and gatekeeper:

"I am my patient's advocate, yet daily I am asked to make life and death decisions by the ever shrinking pocketbook. ... I know medical costs have skyrocketed, but medicine of the '90s can't look only at spread sheets and cost centers. Each HMO enrollee is a living, breathing human. These people must be able to count on their physician to be their confidante, their advocate, their navigator of the rough waters of the insurance-corporate-medical establishment."⁴

These potential conflicts have led many people to question whether providers, physicians in particular, can truly serve the interests of their patients in an ethical manner in the face of financial incentives for, at best, practicing quality medicine cost-

effectively (the mantra of managed care) and, at worst, for limiting needed and effective care (the fear of the dark). Incentives themselves are not new to medicine. Good arguments can be made that fee-for-service medicine, with an economic incentive that favors overutilization, has been fraught with abuse and leads to the provision of unnecessary care. Stark I and II exist because studies have demonstrated abuses and overutilization of the fee-for-service system. However, just because fee-for-service reimbursement has the possibility for perverse incentives does not mean that same possibility should be ignored under the managed care paradigm.

The fiduciary ethic and the conflicts it evokes under capitation are succinctly addressed in Marc Rodwin's "Medicine, Money and Morals—Physicians' Conflicts of Interest."⁵ Rodwin's analysis addresses both historical and contemporary responses to the issue of physician

conflicts of interest, but notes that it was only in the 1980s that organized medicine adopted formal positions on the topic.

Rodwin's main premise is that the fiduciary ethic is in real danger when either incentives or disincentives are used to regulate patient care for solely financial reasons. In particular, Rodwin attacks the concept of risk transfer, pointing out that as the potential impact of financial incentives increases, so does the potential impact on the physician's loyalty to the fiduciary ethic. In a section entitled "The Corrosive Effects of Risk-Transfer Incentives," Rodwin argues: "Society makes a statement about the role of physicians when it provides incentives for them to help government or health care organizations reduce their costs. This is especially so if there are no equivalent financial incentives for physicians to improve quality of care. By using financial incentives to change the clinical prac-

patient's best interests.

(e) Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

(f) Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

(g) Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

3. When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at

risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

(a) Any incentives to limit care must be disclosed fully to patients by plan administrators upon enrollment and at least annually thereafter.

(b) Limits should be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

(c) Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

4. Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs.

Reprinted with permission from: Council on Ethical and Judicial Affairs, American Medical Association. Report 60: Ethical issues in managed care. In: Code of medical ethics reports, vol. V, no. 2. Chicago: American Medical Association, July 1994. © 1994 American Medical Association.

tice of physicians, society calls forth self-interested behavior."

Rodwin and others argue that financial incentives weaken the informed consent process, which should include disinterested assessments, advice, and a review of alternative courses of treatment. The physician working in a capitated arrangement may have incentives to restrict treatment. Beauchamp and Childress observe that "[t]he patient is in a very different position when the physician has incentives to restrict needed treatment than when the physician has incentives to provide unnecessary treatment. In the latter situation, patients can obtain another opinion. In the former situation, patients may never be aware of a needed treatment because no one has recommended it."²

Although he identifies situations where incentives can be and are used in a positive manner, Rodwin sticks to the position that risk transfer is not an ideal mechanism for promoting cost containment. "The best that can be said for risk sharing is that it can be used to limit inappropriate overuse of medical services. But there are other ways to address overuse."

Rodwin outlines two possible ways to deal with the perceived problems of risk sharing. First, he suggests restricting the amount of risk physicians would be allowed to bear to 1 percent to 2 percent of base income. Second, he suggests that organizational providers should be liable for the malpractice caused by the underuse of services by affiliated physicians. The federal government is suggesting something similar to Rodwin's first idea for its Medicare/Medicaid risk-based contracts, but with an upper limit of 25 percent to 30 percent. The federal regulations are in response to legislation addressing the possibility of underutilization of resources for Medicare and Medicaid patients. Interestingly, in the commentary to the regulations, concerns about underutilization were based on perception rather than any documented cases of abuse.

Reform and Ethics

Like Rodwin, Gray analyzes and acknowledges the many changes in

medicine that threaten the fiduciary ethic, including physician ownership of facilities, joint ventures, utilization management organizations, new approaches to cost containment, and a variety of other reforms. Such threats notwithstanding, he concludes that preservation of the fiduciary ethic "as a fundamental principle orienting the behavior of the physi-

**"At what level of
capitation is
physicians' fiduciary
duty to place their
patients' interests
above all others
weakened or ethically
compromised?"**

cian" must be an important element of health system reform. It can be argued that this principle becomes even more important as health care continues its march toward further integration.¹

Susan Wolf, associate professor of law and medicine at the University of Minnesota, recently addressed the fiduciary ethic in the context of health system reform. In her article, "Health Care Reform and the Future of Physician Ethics,"⁶ Wolf finds that under recent reform proposals, physicians will ultimately bear the burden of implementing reform in patient encounters and will continue to have the ethical responsibilities imposed by the physician-patient relationship. What appears most disturbing to Wolf is that in fulfilling those responsibilities, "[t]here is no assurance for patients, health plans, or regional and corporate alliances that physicians will act in some consistent and ethically defensible way."

Wolf proposes a framework of physician responsibility that would apply when a health plan expressly limits benefits and when it relies on the physician as gatekeeper. Wolf

says that "the physician's duty should be to inform the patient of all potentially beneficial treatment; to inform the patient of barriers to treatment (including contract barriers under the particular plan) or to refer the patient to personnel who can explain the plan; and to determine what advocacy to undertake for the patient within the organization." When the physician is a gatekeeper, implicit in capitated arrangements, Wolf proposes that the duty to provide and advocate for care increases with the potential benefit of the care.

Perhaps the most compelling part of Wolf's article is her support for a system of "organizational ethics" that recognizes "that a physician is one actor in a health care organization and larger system." In effect, she says, large systems should have their own clearly defined ethical guidelines. This point is especially cogent given the creation of ISNs in Minnesota. In agreement with Rodwin, Wolf claims that financial incentives should not be used to deny access to "potentially beneficial treatment." Arguing that roles and procedures for patients, physicians, and insurers should be clear and that "fair procedures" should be in place to allow for advocacy on both initial determinations and denials of benefits, Wolf formulates a number of guidelines to address the ethical aspects of the complex relationships in the changing health care environment.

Wolf is not alone in calling for such guidelines. The Joint Commission on Accreditation of Healthcare Organizations has set new standards that go into effect this year requiring hospitals to "establish and implement a code of ethical behavior" that addresses the economics of health care services, including relationships with other providers and payers. The American Medical Association's Council on Ethical and Judicial Affairs' "Code of Medical Ethics" offers guidelines for physicians who are trying to reconcile conflicting roles. In "Report 60: Ethical Issues in Managed Care,"⁸ the council addresses the conflicts between physicians and patients when there are financial incentives to limit care. The guidelines (reprinted on page 24) reaffirm

the primacy of the physician as advocate and set forth numerous principles to address the conflict of interest engendered by financial incentives. These principles include allowing only those financial incentives that promote cost-effective care, disclosing incentives to patients, limiting the size of incentives, and pairing incentives based on quality with those based on quantity.

Conclusion

Given that risk sharing is an essential element of capitation, the challenge is to preserve the fiduciary ethic to the extent possible and to disclose to the patient when it is being redefined and infringed upon. The physician's role as caretaker, confidante, advocate, and navigator must be reconciled with that of insurer. If a reconciliation is possible, it will likely be through measures such as those advocated by the Council on Ethical and Judicial Affairs. If an ethical balance cannot be achieved, then the very concept of risk sharing must be reconsidered. MM

Gordon Apple has recently returned to private legal practice after serving as general counsel to Ramsey Clinic Associates, St. Paul-Ramsey Medical Center, and Ramsey Foundation.

REFERENCES

1. Gray BH. The profit motive and patient care. New York: The Twentieth Century Fund, Inc., 1991.
2. Beauchamp T, Childress J. Principles of biomedical ethics. 4th ed. Cambridge, England: Oxford University Press, 1994.
3. Morreim EH. Balancing act: the new medical ethics of medicine's new economics. Netherlands: Kluwer Academic Publishers, 1991.
4. Bossen AN. We should call it profit care, not managed care. New York Times 1995 February 26; Sect. F:24.
5. Rodwin MA. Medicine, money, and morals: physicians' conflicts of interest. Oxford, England: Oxford University Press, 1993.
6. Wolf SM. Health care reform and the future of physician ethics. Hastings Cent Rep 1994(2):28-41.
7. Council on Ethical and Judicial Affairs, American Medical Association. Ethical issues in managed care. JAMA 1995;273: 330-5.

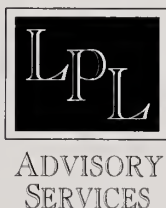
800 No-Load Mutual Funds

Professional Management Through Asset Allocation

One Consolidated Statement

No Commissions*

*If this sounds like a better way to invest, call today
and ask me about our SAM program.*



Wayne E. Bernardo

2500 Foshay Tower
Minneapolis, MN 55402
(612) 337-8484
(800) 755-5877

*Investors in SAM pay a small annual fee based on account value; nominal transaction costs occur.

LINSCD/PRIVATE LEDGER A REGISTERED INVESTMENT ADVISOR

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.

Employee Benefits Attorneys
2600 Eagan Woods Drive, #450
Eagan, MN 55121-1152

Practice limited to ERISA since 1988

Tel: 612-452-9322
Fax: 612-452-9355

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Celiac Sprue in an Asymptomatic Elderly Man

Nic R. Cordum M.D., Brendan M. McGuire, M.D., and Douglas Nelson, M.D.

ABSTRACT

The authors discuss the case of an asymptomatic patient with celiac sprue presenting with hematologic abnormalities on screening laboratory examination. The patient was initially treated for vitamin B-12 and folate deficiency, and subsequently for iron deficiency with limited success until the diagnosis was established. The absence of such classic features of celiac disease as steatorrhea and diarrhea is not an uncommon presentation. Unexplained iron deficiency should alert the clinician to the possibility of celiac sprue.

Celiac sprue (celiac disease, nontropical sprue, gluten sensitive enteropathy) is a relatively common cause of malabsorption worldwide. Several etiologies have been proposed, including genetic factors, enzyme deficiencies, abnormal glycosylation of glycoproteins, and immune-related mechanisms. Diagnosis rests on typical histologic findings on small bowel biopsy and clinical and histologic improvement after withdrawal of gluten from the diet. Celiac sprue can present with a wide variety of manifestations secondary to malabsorption, most commonly as diarrhea and weight loss. We present an asymptomatic elderly male with celiac sprue who had signs of combined vitamin B-12, folate, vitamin K, and iron deficiency, but in whom diarrhea was never a symptom.

CASE PRESENTATION

The patient was a 71-year-old white man with a history of Pott's disease and secondary T5 cord compression with paraplegia since 1946, found to have a profound pancytopenia and macrocytosis (see table, page 30). There was no history of hematologic abnormality. The patient denied abdominal pain, bloating, diarrhea, and weight loss. The patient had formed stools every one to two days, with occasional use of suppositories for constipation. Physical exam revealed muscle wasting and a T5 paraplegia with spastic paraparesis. As can be seen from the table, the patient's vitamin B-12 and folate levels were markedly decreased, his albumin was 2.4 g/dL (normal 3.9 to 4.9), his cholesterol was 101 mg/dL, and his prothrombin time was prolonged. A bone marrow biopsy revealed classic changes of megaloblastosis. Stage one and two Schilling tests were both

abnormal, indicative of malabsorption. The patient's primary physician began intravascular vitamin B-12, oral folate, and vitamin K replacement. The table shows the resolution of the patient's macrocytic anemia with vitamin supplementation over the next two months.

A year after presentation, the patient returned to the primary physician, complaining of malaise and a 5 kg weight loss. Screening blood counts revealed a microcytic anemia. Subsequent iron studies showed an iron level of 19 µg/dL (normal 50 to 160), transferrin saturation of 5.1 (normal 14 to 50), and ferritin level of 5.6 ng/mL (normal 15 to 300). The patient denied melena and was guaiac negative on three occasions. Air contrast barium enema and flexible sigmoidoscopy revealed no gross abnormality. The primary physician began the patient on oral iron replacement, but a year later his hemoglobin had increased only to 10 g/dL and his microcytosis persisted. Intramuscular iron therapy was initiated, which was poorly tolerated and ultimately discontinued.

Two years after his initial evaluation, the patient returned with symptoms of early satiety, intermittent nausea, and a 15 kg weight loss without diarrhea. The patient was referred for consultation to the gastroenterology service. Review of the patient's course to date prompted an upper endoscopy showing velvety duodenal mucosa and the notable absence of duodenal folds, suggestive of sprue. Small bowel biopsy revealed extensive villous atrophy, crypt hyperplasia, and a chronic inflammatory infiltrate of the lamina propria consistent with sprue. Confirmatory serum IgA and IgG anti-gliadin antibodies were measured and found to be markedly elevated at

Hematologic parameters before and after diagnosis of celiac sprue

	Presentation	2 months B-12 therapy	1 year	4 months gluten-free diet
Hgb (g/dL)	9.9	11.8	8.2	13.7
MCV(fl)	120	97	63.5	89
WBC (cells/dL)	2800	5200	4100	7300
Platelets (10 ³ /dL)	85	247	506	312
Folate (ng/dL) (N 2-14)	1.2	5.1	5.6	10.3
B12 (pg/dL) (N 150-800)	<100	>1000		732
Prothrombin time (sec) (N 11.2-13.3)	13.6	11.4		

79 U (normal <4 U) and 117 U (normal <15 U), respectively. The patient was started on a gluten-free diet. Four months after initiation of the gluten-free diet, repeat small bowel biopsies demonstrated normal villous architecture with only mild chronic inflammation. The patient regained nearly all of his 15 kg weight loss, and his blood counts normalized.

DISCUSSION

Although the diagnosis of a malabsorptive disorder was evident on initial laboratory investigation, definitive diagnosis and therapy of celiac sprue in this patient was delayed two years. Absence of classic symptoms of malabsorption contributed to this delay, illustrating several important teaching points.

Diarrhea in celiac sprue is presumably multifactorial, including an increased osmotic load from malabsorption of fatty acids, electrolytes, proteins, and water; motility dysfunction from abnormal gut hormonal secretion; and catharsis from bile acid and hydroxy fatty acid malabsorption.¹ The malabsorption is thought to be from disruption of the enterocyte brush border and overall decrease in functional absorptive area of the

involved portion of small bowel.^{1,2}

Review of the literature suggests that the absence of diarrhea is not uncommon.^{1,3-6} The severity of mucosal involvement in celiac sprue commonly decreases in the distal bowel. This may account for the absence of diarrhea in those patients whose disease is limited to the proximal small bowel.^{1,2} In this patient, evidence of iron and folate malabsorption (absorbed proximally), and vitamin B-12 malabsorption (absorbed in the ileum), suggests that his entire small bowel was involved. This degree of involvement should result in significant fat malabsorption and subsequent steatorrhea. However, a detailed dietary history from the patient revealed a gradual but almost complete avoidance of dietary fat for the preceding several years to avoid bloating and diarrhea. While it is possible that the patient's history of neurogenic bowel dysfunction secondary to his T5 paraplegia could have mitigated against diarrhea, the self-regulation of dietary fat most likely accounts for his lack of symptoms.

Iron deficiency anemia may be the initial presentation of celiac sprue in many cases.^{1-3,7} In the adult population, it is important to exclude

gastrointestinal blood loss as a cause of iron deficiency. However, this case emphasizes that malabsorption of iron should be considered for patients in whom gastrointestinal blood loss has been excluded.

In summary, this case emphasizes the following points:

- Classic symptoms of malabsorption, including diarrhea, may not be present in all patients with celiac sprue.

- A careful dietary history may reveal self-regulation of diet that may delay the diagnosis of malabsorptive disorders like celiac sprue.

- Iron deficiency in patients without evidence for gastrointestinal or other source of blood loss should raise the concern for malabsorption. **MM**

Nic Cordum is a fellow in gastroenterology at the University of Kansas Medical Center in Kansas City, Kansas. He was the chief medical resident at the Veterans Affairs Medical Center in Minneapolis at the time this manuscript was prepared. Brendan McGuire is a fellow in gastroenterology at the University of Minnesota Hospital and Clinic in Minneapolis. Douglas Nelson is an assistant professor in medicine, Gastroenterology Division, Minneapolis-VAMC.

REFERENCES

1. Kagnoff MF. Celiac disease. In: Yamada T, Alpers DH, Owyang C, Powell DW, Silverstein FE, eds. Textbook of gastroenterology, vol. 2. Philadelphia: J.B. Lippincott Co., 1991:1503-20.
2. Trier JS. Celiac sprue. *N Engl J Med* 1991;325:1709-18.
3. Paré P, Douville P, Caron D, Lagacé R. Adult celiac sprue: changes in the pattern of clinical recognition. *J Clin Gastroenterol* 1988;10:395-400.
4. McGuigan JE, Volwiler W. Celiac-sprue: malabsorption of iron in the absence of steatorrhea. *Gastroenterology* 1964;47:636-41.
5. Mann JG, Brown WR, Kern F Jr. The subtle and variable clinical expressions of gluten-induced enteropathy (adult celiac disease, nontropical sprue). *Am J Med* 1970;48:357-66.
6. Hankey GL, Holmes GKT. Coeliac disease in the elderly. *Gut* 1994;35:65-7.
7. Gostout CJ. Enteroscopy for unexplained iron-deficiency anemia: identifying the patient with sprue. *Gastrointest Endosc* 1993;39:76-9.

Because children aren't childproof...



we provide specialty services in pediatric rehabilitation.

We offer comprehensive inpatient and outpatient pediatric rehabilitation for children with brain injuries, spinal cord injuries and other disabilities including evaluation, treatment, discharge planning and follow-up. Services include:

- pediatric physical medicine & rehabilitation
- pediatric neurology
- physical, occupational and speech therapy
- psychological assessments & counseling
- educational programming
- family support & education
- equipment and assistive technology consultation

To make a referral, call **(612) 229-3819** Inpatient
(612) 229-3845 Outpatient
(612) 229-3928 TDD

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

a regional health center for children and adolescents who have disabilities

Family Practice Opportunity at the Family Medical Clinic in Amery, Wisconsin



Come join a dynamic ten-physician primary care practice and live in Wisconsin's beautiful lake country.

Affiliated with Ramsey Clinic, a large multi-specialty group practice, and the St. Paul-Ramsey Medical Center, a leading tertiary care center, physicians have access to immediate consultations, helicopter support, research and teaching opportunities and financial security.

Amery is a charming community of 2800, sprinkled with lakes and rivers, and located within an hour of the Twin Cities. Physicians have never left, only retired.

Please contact Aynsley Smith at Ramsey Clinic
Department of Professional Services
640 Jackson Street
St. Paul, Minnesota 55101
or by phone at 612-221-4230
or via facsimile at 612-221-8571

Ramsey Clinic

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469

•••**EMERGENCY MEDICINE POSITIONS**•••

Northern and Central Minnesota

Emergency Medicine opportunities are available now. Full-time and part-time staff positions in moderate volume emergency departments. Attractive, comprehensive benefit packages with paid malpractice. Beautiful surroundings, numerous recreational activities, excellent schools in economically stable, safe, family-oriented communities. Practice medicine in friendly professional environments at a pace that allows ample time for family and leisure activities. Call today for more information.

Iowa

Opportunities for prosperous lifestyles in several friendly Iowa communities. Secure practices with progressive physician-owned group. Excellent compensation packages, pleasant working conditions with appreciative patients. Various locations, reasonable housing in safe communities with top-notch school systems and Midwest values. Life in Iowa is measured by its warm, friendly people and quality lifestyles.

Come join us.

- Call 1-800-458-5003 or send CV to Sheila Jorgensen, P.O. Box 1260, Waterloo, IA 50704

.....
Come visit us during the MN Academy of Family Physicians Annual Meeting. Booth 325.

***St. Croix Falls
Wisconsin***

Community of 2000 seeks additional Family Practitioner. Practice consists of 13 Family Practitioners, 2 Internists, 1 General Surgeon and 1 Orthopedic Surgeon. Many specialists available on a part-time basis. We are attached to a 90-bed hospital with comprehensive service available. We have a stable medical group with pleasant working conditions in a continuous growth mode.

We are 50 miles NE of the Twin Cities. We offer guaranteed first year salary with second year partnership, and excellent fringes including retirement package.

Send detail CV to:

Cathy Kortas
River Valley Medical Center
208 S. Adams Street
St. Croix Falls, WI 54024
(715) 483-3221

***COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes***

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C. F.
anderson
COMPANY, INC.

ANNOUNCEMENTS

• • • • •

DR. JACOTT RUNS FOR RE-ELECTION

William E. Jacott, M.D., is a candidate for re-election to the American Medical Association Board of Trustees for a third term. He runs unopposed in an election to be held at the AMA Annual Meeting in June. The Minnesota Medical Association strongly supports Jacott's candidacy.

• • •

MSBA-MMA DINNER IS MAY 22

"The New Antitrust Guidelines and the Case for Antitrust Reform" will be the topic of the fifth annual Minnesota State Bar Association-Minnesota Medical Association dinner, 5:30 p.m. to 8:30 p.m., May 22 at the Sheraton Midway Hotel in St. Paul. Featured speakers are Edward Hirshfeld, J.D., AMA office of the general counsel, and Mark Mishek, J.D., Allina Health System. They will address the new antitrust guidelines, antitrust reform legislation, and the third-party payer and health plan perspective on changes in antitrust laws. The implications of the Marshfield Clinic decision will be discussed.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for 2 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

The registration fee is \$41. For more information, or to register, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MinnesotaCare Bills Move Forward

As *The Monitor* goes to press, the MinnesotaCare legislation is almost ready to move to the House and Senate floors, but the bills are still changing daily. Controversial amendments are being tacked on and stripped off as the bills move through the final committees. The major MMA proposals that are in both House and Senate bills are: repeal of RAPO, repeal of further community rating based on age, utilization review provisions, and data provisions. Proposals that are still embroiled in controversy are: the increase in the tobacco tax, the free-rider penalty, eligibility levels for MinnesotaCare, and point-of-service requirement. Proposals that seem to have lost momentum are the medical savings account provision and the public safety provisions.

Cut Provider Tax, Raise Cigarette Tax, MMA Urges

The MMA strongly supports recent efforts to cut the provider tax in half and to raise the cigarette tax to fund the MinnesotaCare program. This proposal has had its ups and downs, and, as *The Monitor* goes to press, its fate is still uncertain. Attempts began in the Senate Taxes and Tax Law Subcommittee on Income and Sales Tax when Sen. Bill Belanger, IR-Bloomington, offered an amendment to the Omnibus Tax Bill that would reduce the provider tax from 2 percent to 1 percent and offset it with a 40-cent tobacco tax increase. The amendment passed by an 8-3 vote. The full Senate Tax Committee, however, deleted the amendment the next

day. Planning to offer the two parts of the proposal separately, Sen. Sheila Kiscaden, IR-Rochester, offered a 25-cent cigarette tax increase as an amendment to the Omnibus Tax Bill on the Senate floor. Her proposal failed. Kiscaden plans to try again. The one-time 40-cent cigarette tax bill, S.F. 1080-Price, is now before the Senate Tax Committee, and Kiscaden intends to offer an amendment lowering the provider tax and raising the cigarette tax by 25 cents the first year with an annual increase of an additional 7 cents in following years. This proposal would be budget neutral. Sen. Doug Johnson, DFL-Cook, chair of the Tax Committee, opposes this proposal, as does the Senate author of the MinnesotaCare bill, Sen. Linda Berglin, DFL-Minneapolis. Berglin believes the cigarette tax is too unstable to serve as a funding source for MinnesotaCare.

Gov. Arne Carlson remains strangely silent on this proposal, even though he has said the only way he would support a cigarette tax increase is if it were offset to be budget neutral. The MMA has written to the governor, asking for his support for the current proposal, but Carlson refuses to state a position. The MMA continues to lobby heavily in favor of the proposal. The MMA's health reform bill included a sunset of the 2 percent tax and a 40-cent tobacco tax hike.

Free-Rider Penalty Is in Trouble

In the House Tax Committee, IR lawmakers succeeded in taking out

MinnesotaCare continued on page 35



Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

Direct Contracting Can Put Doctors in the Driver's Seat

Legislation to allow direct contracts between providers and self-insured companies was a late-comer to this year's health reform debate, but the idea has caught on and its popularity is growing. This proposal, developed by the Minnesota Hospital Association, creates a new option that would reassign current roles and put providers—physicians and hospitals—more in control of health care delivery. It would eliminate the middleman, the health plan.

Although the MMA has taken no formal position on the "deal direct" proposal, it is in line with MMA policy favoring a wide range of options in the marketplace and encouraging arrangements that allow physicians to play a key decision-making role.

Under this new option, health plans would not call the shots. They would provide capital, information systems, or administrative services to the provider co-ops that contract directly with employers, or they would compete with them.

For physicians who don't want to lose their independence, direct contracting offers a very attractive alternative. Physicians who choose this option would be able to make medical decisions without the restrictions imposed by health plans. Direct contracting arrangements also promise to be cost-effective. Physi-

cians are in the best position to decide how care can be provided efficiently without cutting corners. They have the expertise to know when cost containment is appropriate and when it cuts into the quality of care. In this scenario, cost savings from improved efficiency would not be diverted into health plan coffers.

The MHA developed the direct contracting legislation as a way to further a concept it introduced last year—the health care cooperative. Co-ops that contract directly with employers would be one more option in the marketplace along with HMOs, indemnity insurance, ISNs, and CISNs. Cooperative arrangements would allow physicians to maintain their independence and at the same time to share management services, data on patient outcomes, medical records, and administrative services, as well as to negotiate with purchasers.

The direct contracting idea received a boost in February when the Business Health Care Action Group announced that it will contract with additional provider systems beginning in 1997. When it formed, the BHCAG, a coalition that now includes 23 employers, contracted exclusively with one large plan for health care services. Now, in an effort to increase competition and choice for enrollees, the coalition is expanding its choices.

The 1994 MinnesotaCare legis-

lation created two kinds of cooperatives: 1) provider co-ops formed by physicians, clinics, or hospitals to sell health care services on a capitated basis to large buyers, and 2) purchasing co-ops of employers, individuals, or local units of government.

Although the powerful HMO Council had no problem with the provider co-ops dealing directly with self-insured employers, it opposed allowing direct contracting by purchasing pools of employers. After much discussion, MHA agreed not to pursue a purchasing pool proposal during the current legislative session so that the "deal direct" legislation could go forward.

With this agreement in place, Rep. Roger Cooper, DFL-Bird Island, successfully offered a direct contract amendment to the LOC bill in the House MinnesotaCare Division of the Health and Human Services Committee on April 12. This amendment would allow the co-ops, created by last year's MinnesotaCare legislation, to contract with medium and large self-insured employers to provide health care services to the employees and dependents covered under the self-insured plan. Co-ops would have to register with the state and comply with certain solvency and quality assurance standards. Cooper's amendment was adopted without opposition.

The current amendment allays fears that it would encourage more employers to self-insure and thus avoid state regulation and taxation under ERISA, the Employee Retirement Income Security Act. The amendment requires any plan that contracts with a co-op to voluntarily pay a 1 percent premium tax, a Minnesota Comprehensive Health Association (MCHA) assessment beginning in 1997, and the MinnesotaCare provider tax. The plan must also voluntarily agree to comply with the state's data submission and administrative simplification provisions.

As *The Monitor* goes to press, the direct contracting amendment is not on the Senate version of the bill. This is the time for supporters to talk to their legislators.

• • • • •

ANNOUNCEMENTS

• • • • •

WORKSHOPS ON WORKERS' COMP PARAMETERS

Health care providers are invited to attend a workshop on Minnesota Workers' Compensation Permanent Treatment Parameters, presented by the Medical Services Review Board and the Department of Labor & Industry. Workshops will address the following topics:

- why and how treatment parameters were developed,
- responsibilities of health care providers,
- responsibilities of payers,
- differences between the emergency rules and the permanent parameters,
- review of administrative parameters on prior notification, requests to review a payer's denial of services, and the appeals process.

The workshops will begin with a light supper at 6 p.m. and are scheduled to end at 9 p.m. Dates and locations of the workshops are listed below:

May 2, St. Cloud, Radisson Hotel

May 9, Mankato, Holiday Inn

May 11, Duluth, Radisson Hotel

May 17 and May 22, St. Paul, Earle Brown Center

May 23, Fargo, Radisson Hotel

The registration fee of \$25 per person includes a light supper, an information packet, and a copy of the "Permanent Treatment Parameters." For further information, call Shirley Reese, Department of Labor & Industry, 612/297-3970.

MinnesotaCare continued from page 33

the MinnesotaCare bill's free-rider penalty. This provision, which was also in the MMA's reform bill, would mean a loss of their personal income tax deduction for Minnesotans who can afford health insurance but choose not to buy it. The governor opposes the tax penalty. In the Senate Tax Committee, Berglin successfully offered an amendment that she believes will have a better chance of passing. It would change the free-rider penalty into a \$100 loss of deduction the first year a person was uninsured, a \$200 penalty the second year, and a \$400 penalty the third year. This language represents a compromise with the Department of Revenue, which opposed the original version, and with the Department of Health. David Renner, MMA director of legislation and policy, testified in favor of the embattled free-rider provision. "The MMA strongly supports an income tax incentive for people to buy insurance. This was a key piece of the MMA's Quality and Coverage bill, offered as an alternative to the insurance mandate," Renner said. "The income tax incentive encourages personal responsibility, and it will stabilize, if not reduce, insurance premiums." Representatives of the Minnesota Health Care Commission and the Minnesota Chamber of Commerce also testified in favor of the free-rider penalty. The Senate Tax Committee accepted Berglin's amendment on a voice vote.

MMA's Point-of-Service Option Is on House Bill

In the House version of the MinnesotaCare bill, a point-of-service option must be one of the five required cost-sharing arrangements. Comfort language for Blue Cross and Blue Shield makes it clear that the out-of-network option can be more expensive. This provision affects health

plans with more than 50,000 enrollees and applies only to the plans offered to employers, not to individuals. Point-of-service is not in the Senate bill, which requires plans to offer any two of the five cost-sharing options.

Eligibility Level Is Veto Bait

One of the most controversial MinnesotaCare provisions would raise the current eligibility level for the MinnesotaCare program. If Minnesota receives its federal waiver to combine state programs, the bill would increase eligibility from 125 percent of the poverty level (\$9,200) to 150 percent of the poverty level (\$11,040) for individuals without children. The governor has threatened to veto the entire bill if it increases eligibility. The proposal has survived numerous attempts to kill it or to reduce it. Most recently, in the House Taxes Committee, a proposal to reduce eligibility from 150 percent to 135 percent of poverty failed on a 5-5 vote.

House Bill Allows Direct Contracting

An amendment that would allow health care provider co-ops to directly contract with self-insured employers was successfully offered by Rep. Roger Cooper, DFL-Bird Island, in the MinnesotaCare Division of the House Health and Human Services Committee on April 12. This provision is on the House but not the Senate bill. (See Viewpoint by Andrew J. K. Smith, M.D., on page 34 for more information.)

House Bill Includes Abortion Amendment

The House Health and Human Services Committee approved an amendment that would no longer require health plans to cover abortion as part of a standard policy. • • • • •

MMA Strongly Opposes Vulnerable Adults Act

Although the Minnesota Medical Association has convinced legislators to make important improvements in the Vulnerable Adults Bill, the MMA strongly opposes this bill because it would criminalize health care decision making and authorize felony prosecutions of the caregivers of vulnerable adults. The bill, H.F. 598-Greenfield/S.F. 512-Spear, would create severe felony penalties for criminal neglect—fines up to \$20,000 and up to 10 years in prison. The MMA fears these penalties will encourage prosecutors to mount aggressive investigations of health care providers and of the family members of vulnerable adults if there is a bad outcome. Cases now prosecuted as civil negligence or malpractice could move into the criminal courts. Although the attorney general's office has offered assurances that only providers in "very egregious situations" will be affected by this new law, the MMA fears it will set a dangerous legal precedent and will criminalize mistakes and carelessness. The language of the bill casts a wide net authorizing the state to intervene even when the caregiver intended no harm.

First enacted in 1980, the Vulnerable Adults Act is intended to protect patients in a hospital, nursing home, or other licensed facility, as well as individuals with a physical, mental, or emotional dysfunction that impairs their ability to protect themselves. Under the current law, a person who intentionally fails to supply food, clothing, shelter, or other necessities to a vulnerable adult could be charged with criminal neglect, a misdemeanor punishable by up to one year in jail and a fine of up to \$3,000. Changes to the law proposed in this session's House bill would define criminal neglect as acting with "conscious disregard for danger to human life and reckless indifference to the risk of harm,"

and would make it a felony offense punishable by fines of up to \$20,000 and up to 10 years in prison.

The MMA supports the intent of the bill—to protect the vulnerable—but is concerned that the Vulnerable Adults Bill will not distinguish between caregivers who act in good faith and those who intend to do harm. Currently, a caregiver or health care provider who makes a wrong decision about treatment or who makes an error that leads to serious injury would generally be dealt with through administrative action, licensing board action, and/or civil or professional liability lawsuits. The MMA contends that these are more appropriate ways to discipline people who intend no harm than prosecuting them in criminal court. Under the proposed law, malpractice actions could lead to criminal investigations. Professional liability insurance does not cover defense for criminal prosecution.

Testifying for the MMA before the House Judiciary Committee on April 5, Robert Meiches, M.D., an MMA trustee and a primary care physician who works with geriatric patients in ambulatory and nursing home settings, described a possible scenario. He asked committee members to imagine working in a nursing home as a nursing aide, "the worst-paid person in the world," at the bottom of the totem pole, receiving little or no respect and taking care of the bodily functions of frail and elderly patients. The aide is told to put on the patients' slippers before letting them leave their beds. But one day an elderly man urgently needs to go to the bathroom and resists putting on his slippers first. Under pressure, the nursing aide lets the patient go barefoot despite reminders not to do this. If the elderly patient falls and breaks his hip, he could die. "Under the proposed law, people doing their

best in a terrible situation would be potential criminals if there is a bad outcome," Meiches said.

After lengthy negotiations, the MMA reached an agreement with the bill's House author, Lee Greenfield, DFL-Minneapolis, on an amendment that would require that the act or omission must be more than ordinary and gross negligence. It is significant that the amendment excludes "therapeutic conduct" from the definition of criminal neglect so the law will not apply to treatment plans that go awry. The House Judiciary Committee adopted the amendment and passed the Vulnerable Adults Act on April 5.

The Greenfield amendment is an improvement, but it is not currently in the Senate version of the bill. By working behind the scenes, the MMA has achieved other improvements in the Vulnerable Adults Bill. In the original bill, failure to report was a felony; it is now a misdemeanor in the Senate bill and a gross misdemeanor in the House bill. Despite improvements, however, the MMA remains adamantly opposed to the bill.

There is a \$3 million fiscal note attached to the bill. This does not include the cost of the expected increase in investigations. Hidden costs to the health care industry are likely to reach several million dollars annually.

As *The Monitor* goes to press, the bill is scheduled to be heard in the House Ways and Means Committee before heading to the floor. In the Senate, the bill awaits a hearing in the Finance Committee before being sent to the floor. According to the "MMA Call to Action," which alerted the MMA's legislative network of the need to contact legislators, "The adversarial legal climate this bill creates is likely to further the exodus of families, friends, and professional staff away from caring for vulnerable adults. The bill will also create another barrier to recruiting quality clinic assistants, nurses, and other professionals." ♦ ♦ ♦ ♦ ♦

LEGISLATIVE NEWS

MMA INTRODUCES ANTITRUST LEGISLATION

The Minnesota Medical Association drafted antitrust legislation that would have authorized clinics with fewer than 20 physicians to bargain collectively without any economic or professional integration. This proposal, introduced by Duluth DFLers Rep. Tom Huntley and Sen. Sam Solon, would apply only if the clinics were negotiating with large, powerful third-party payers. The bill, H.F. 812, failed to receive a hearing this session, but it stimulated discussion and made lawmakers more familiar with physicians' antitrust concerns. The issue will probably be raised again next session.

MMA OPPOSES CUTS IN GAMC REIMBURSEMENT

In an effort to save the General Assistance Medical Care (GAMC) services that were eliminated by the governor's budget, the Senate Health Care and Family Services Finance Division adopted an amendment to the Health and Human Services Omnibus Bill that would reduce provider reimbursement rates for all GAMC outpatient services by 5.4 percent. The rate was later amended to 5.13 percent. This across-the-board "rateable reduction" for all providers is intended to raise close to \$18 million to buy back specific GAMC services, including inpatient mental health services, that the governor wants to cut.

The MMA opposes the rateable reduction, arguing that the decrease in provider reimbursement violates the promises that legislators made to physicians in 1993 when they imposed a \$400 surcharge on medical licenses in order to increase reimbursements for Medical Assistance and General Assistance Medical Care. At that time, legislators said they would never allow

public program reimbursement to drop as far below market payments as they were in 1993. If rates are cut this year, the gap between public program rates and the market rate will become a chasm if the federal government turns MA over to the states. Lower GAMC reimbursements are bound to reduce access and increase cost shifting.

As *The Monitor* goes to press, the House is preparing its companion bill. Although the bill's author, Rep. Lee Greenfield, DFL-Minneapolis, has said he does not want rateable reductions this year, he will be faced with the task of trimming nearly \$100 million from the human services budget.

MMA SUPPORTS EFFORTS TO KEEP CHILDREN FROM SMOKING

Fighting to reduce children's access to tobacco, the MMA supported a bill, proposed by Sen. Ember Reichgott Junge, DFL-New Hope, and Rep. Ann Rest, DFL-New Hope, that would have required stores that sell tobacco to be licensed by the local government, and would have required compliance checks and set penalties for violations of the law. This legislation failed to meet committee deadlines and is dead for this session.

But in an ironic twist, provisions to keep children from buying cigarettes have been amended onto the tobacco industry's bill, S.F. 558-Sams. Originally, this modest proposal called only for a training program for tobacco retailers, and it would have pre-empted stronger local ordinances. In a victory for the MMA and the Smoke Free 2000 Coalition, however, the Senate Commerce Committee on April 6 adopted amendments to this bill that would require licensing for stores that sell tobacco, would set penalties on selling tobacco to minors, require random checks of compliance with

the law, set up a training program for tobacco retailers, and ban payments to stores for displaying cigarette advertisements. Significantly, the amended bill states that it would *not* pre-empt stronger local ordinances. The bill does, however, set caps on the penalties. These anti-smoking measures are in a precarious position because the House companion bill, H.F. 708, does not include the amendments. Both the House and Senate bills are on their way to the floor. If they pass, the significant differences between them will have to be worked out in conference committee.

BMP DISCIPLINARY ACTION BILL IS SIGNED INTO LAW

The Legislature passed and the governor signed into law the Board of Medical Practice's housekeeping bill, S.F. 72-Piper/H.F. 231-Kelley. This legislation automatically suspends the license of a Minnesota physician or other licensed health care professional convicted of a felony "reasonably related" to the practice of medicine. Under this law, convicted physicians will have to request a hearing to regain their license and will have to show "clear and convincing evidence" that they have been rehabilitated. The MMA opposed this legislation, arguing that a felony could be "reasonably related" to the practice of medicine without having any impact on patient care. The law will permanently revoke the license of a doctor convicted of a felony-level criminal sexual conduct offense. In addition, the law will allow the BMP to suspend or revoke the license of a doctor or health professional who fails to repay a state or federal student loan. The MMA argued that it would be more difficult for physicians to pay back their loans if they don't have a license to practice medicine.

LEGISLATIVE NEWS

MMA OPPOSES DISCOUNTS FOR WORKERS' COMP FEES

The MMA strongly opposes a proposal in the House version of the workers' compensation reform bill, H.F. 642-Winter, that would allow certified managed care plans to discount provider fees below the workers' compensation fee schedule.

Providers took a big hit in 1992 when the workers' compensation fee schedule was reduced 15 percent and converted to an RBRVS system. The next year, the MMA successfully lobbied for managed care rules that prohibit certified managed care plans from forcing providers to accept fees below the fee schedule.

The Senate companion bill does not contain a provision allowing discounted fees. The MMA is lobbying to have the provision deleted from the House bill as well.

.....

DRUG PURCHASING BILL FAILS

An improved version of the Minnesota Senior Federation's proposal to develop a statewide purchasing pool to buy pharmaceutical drugs, S.F. 410-Marty, met the first committee

deadline, but its companion bill in the House never received a hearing. Unless the bill is amended onto other legislation it is dead for this session. An attempt to amend the proposal onto the MinnesotaCare bill failed in the Senate Finance Committee.

As introduced, this bill would have allowed the state to negotiate contracts for all the pharmaceutical drugs purchased in Minnesota and would have imposed a statewide drug formulary. Faced with stiff opposition from the MMA and others, the bill's author, Sen. John Marty, DFL-Roseville, amended his bill to make participation in the state purchasing pool voluntary. His bill would also have required hospitals and health plans to disclose contract prices on all drug contracts, including discounts and rebates.

.....

WHAT SHOULD INSURANCE PLANS BE REQUIRED TO COVER?

Rep. Roger Cooper, DFL-Bird Island, is pushing a proposal to change coverage requirements in insurance law from "medically necessary" to "appropriate and

necessary." The change would apply to HMOs but not to indemnity insurance companies. Members of the disabled community support the change because they believe "medically necessary" is too limiting a term to cover chronic care. Mental illness advocates also support the change. Critics say that the existing term is defined through case law and they fear the new broader term will open the door to legal challenges. They also question whether this language would require coverage for alternative medicine. The MMA has taken no position but is studying this controversial issue.

.....

PRESCRIBING BILL PASSES HOUSE

A bill that would require health insurance plans that cover prescription drugs to pay regardless of whether a physician, a nurse practitioner, or a physician assistant wrote the prescription was approved by the House March 30 on a 132-0 vote. The bill H.F. 612, sponsored by Rep. Roger Cooper, DFL-Bird Island, is now going to the full Senate.

Be Prepared for Review Based on E/M Codes

..... BEGINNING SEPTEMBER 1, 1995, evaluation and management (E/M) codes will no longer be excluded from Medicare's medical review system. There will be no random review; physicians will face review only if there is evidence of "significant aberrant reporting patterns." Reviewers will be looking for problems.

Review will be based upon the documentation guidelines for evaluation and management services that were developed by the Health Care Financing Administration (HCFA), working closely with the

American Medical Association. These guidelines are now final and have been given to the Medicare carriers along with the score sheets that will be used to determine whether the reported services were actually provided. Reviewers will not consider medical necessity at this point; they will decide only whether the service was rendered and whether it was reported correctly. Medical necessity review could occur later.

Physicians are not required to use the E/M guidelines in documenting their services. But all physicians are subject to the post-payment re-

view that will be based upon the guidelines. Using the guidelines could reduce some of the hassles associated with claims processing and could serve as a legal document to verify the care provided if this becomes necessary.

If you would like a copy of the E/M guidelines or the score sheets, contact MetraHealth at 612/885-2828 or Blue Cross and Blue Shield Medicare at 612/456-5243. You may also request a copy of the guidelines from the AMA by calling 800/621-8335 and requesting OP924095. For further information, contact Janet Silversmith at the MMA, 612/378-1875.

NATIONAL NEWS

MMA MEETS WITH MINNESOTA DELEGATION, SUPPORTS LIABILITY REFORM, OPPOSES DEEP MEDICARE CUTS

The Minnesota Medical Association leaders traveled to Washington, D.C., to meet with the Minnesota congressional delegation regarding important national issues. The MMA urged the Minnesota senators to support the amendment to the product liability bill, H.R. 956, that would set a \$250,000 cap on non-economic damages in all health care liability cases. The provision passed the House as the Cox-Gehren amendment and is now awaiting action by the Senate. MMA leaders also urged the Minnesota delegation to oppose drastic cuts in Medicare that would further lower reimbursement for Minnesota physicians, who receive lower Medicare rates than physicians in most other parts of the country. Andrew J.K. Smith, M.D., MMA president; Michael J. Murray, M.D., MMA president-elect; and Kenneth W. Crabb, M.D., John R. Balfanz, M.D., Burton S. Schwartz, M.D., and Edward D. Henderson, M.D., met with Sens. Paul Wellstone, DFL, and Rod Grams, IR, and with Reps. Gil Gutknecht, IR, William P. Luther, DFL, and Jim Ramstad, IR.

MMA SUPPORTS LIABILITY REFORM

The MMA wrote to the editors of Minnesota newspapers, urging support for national liability reform. The letter from Andrew J.K. Smith, M.D., MMA president, applauds the U.S. House for passing health liability reform and urges the Senate to do the same. "Americans spend nearly \$50 billion a year on the health care liability system. Patients only receive 43 cents of every dollar awarded and the remaining 57 cents goes to attorneys' fees," Smith wrote.

U.S. SENATE WILL CONSIDER PROFESSIONAL LIABILITY REFORM

Senate action on professional liability reform is expected soon. The Senate Human Resources Committee has reviewed a bill, S.R. 454, introduced by Sens. Nancy Kassebaum, R-Kan., Mitch McConnell, R-Ky., and Joseph Lieberman, D-Conn., that would establish a two-year statute of limitations, allow defendants to pay only the share of damages for which they are responsible, limit attorneys' fees, allow periodic payment of awards over \$100,000, and require states to establish mandatory dispute resolution systems as an alternative to litigation. Unlike the House legislation, H.R. 956, this bill would not cap non-economic or "pain and suffering" awards. The bill's authors fear such a cap would block passage of the bill. The House bill would pre-empt state laws, toughen the burden of proof for plaintiffs, cap punitive damages, and shield obstetricians from liability when they see the mother for the first time. In addition, the Senate Judiciary Committee will soon consider a bill introduced by Sen. Jon Kyl, R-Ariz., that includes a cap on non-economic damages.

MINNESOTA DELEGATION URGES FAIR MEDICARE REIMBURSEMENT

At the request of the MMA, the Minnesota congressional delegation sent a letter to Rep. Bill Archer, chair of the U.S. House Ways and Means Committee, expressing concern with Minnesota's Medicare reimbursement for managed care plans that serve beneficiaries under risk contracts with the Health Care Financing Administration (HCFA) and urging the committee to enact fair reimbursement rates for all states as part of overall Medicare reform efforts. "We believe current federal

reimbursement policies penalize Medicare beneficiaries if they live in or around health care delivery systems that are efficient in achieving the types of health care reforms currently sought by Congress," the delegation wrote. The letter, which also went to ranking minority members of the House Ways and Means Committee and to the Senate Finance Committee, urged Congress to reward rather than penalize Minnesota for its efficiency.

AMA PRAISES WELLSTONE'S PATIENT FAIRNESS ACT

Sen. Paul Wellstone, D-Minn., introduced the Patient Fairness Act in the Senate, which would give patients access to pertinent insurance coverage information, require plans to respect patient responsibilities and rights, and require insurance plans to make clear its benefits and limitations. The AMA issued a statement applauding the bill. Robert E. McAfee, M.D., AMA president, said, "We agree that patients should enjoy freedom of choice of plans and physicians, that their access to physicians should not be impeded, and that physicians should be involved in decisions related to access to medical care services." The AMA is refining the language of its own Patient Protection Act, which will include many of the features of Wellstone's bill.

SELF-EMPLOYED DEDUCTION SIGNED

President Clinton signed into law a bill giving more than 3 million self-employed people the right to deduct their health insurance costs from their 1994 taxes. The bill lets the self-employed deduct 25 percent of the cost of health insurance premiums for themselves and their families.

LEGAL NEWS

COURT REVERSES SELF-REFERRAL DECISION IN HANLESTER LAB CASE

Specific intent to violate the law is necessary to violate the federal anti-kickback statute, according to a recent court ruling. The 9th U.S. Circuit Court of Appeals partially reversed a decision by the Secretary of Health and Human Services that found a laboratory joint venture arrangement had violated the Medicare/Medicaid anti-kickback laws.

The HHS Officer of Inspector General (OIG) had charged that the Hanlester Network, a joint venture arrangement involving three physician-owned clinical laboratory limited partnerships, paid illegal investment returns to physician investors of the labs to induce referrals. The OIG also charged that the labs were merely a "shell" that allowed them to receive remuneration from SmithKline BioScience Laboratories (SKBL), which managed the labs and performed most tests. As a result, HHS excluded Hanlester

from the Medicare program.

Ruling that Hanlester should not have been excluded, the appeals court noted that the appellants had tried to structure the arrangements in a way they believed to be lawful and concluded that the joint venture arrangements did not violate the statute. Actions must be done "knowingly and willfully" to constitute violations. According to the court, the fact that many referrals would probably bring a high return on investment, or that low referral rates could cause the labs to fail, is not sufficient to prove that Hanlester "offered or paid remuneration to induce referrals." The court found that the arrangement with SKBL did not violate the law. This reading of the self-referral law is narrower than the OIG's interpretation in the 1989 Special Fraud Alert.

The court did, however, uphold liability against Hanlester's vice president of marketing, who had told prospective physician investors that eligibility to buy shares depended on

agreeing to refer program-related businesses, that the number of shares they could buy depended on the volume of referrals, and that partners who did not refer businesses would be pressured to leave. The court also found that Hanlester and the labs were vicariously guilty because the vice president of marketing acted as their agent. Nonetheless, this vicarious guilt was not considered sufficient to justify exclusion from the Medicare program.

This court's decision is good news for physicians, but the secretary of HHS could still appeal the case.

CRIMINAL CHARGES ARE FILED

A high volume medical laboratory in Milwaukee was charged with reckless homicide for failing to diagnose the cervical cancers that killed two Wisconsin women. An expert testified at the inquest that the lab missed unmistakable signs of cancer. No charges were filed against the physician who supervised the lab.

ANNOUNCEMENTS

HELP PREVENT BRAIN INJURY

In 1993, 150 cyclists suffered brain injuries requiring hospitalization. Two-thirds of the injured cyclists were children under 19 years of age. Many of these injuries could have been avoided—bicycle helmets are 85 percent effective in preventing brain trauma.

For a free packet of information, encouraging your patients to wear bicycle helmets, contact the Minnesota Injury Prevention Program, Minnesota Department of Health, 717 SE Delaware Street, Minneapolis, MN 55440, 612/623-5285 or FAX 612/623-5775.

CISN SEMINARS OFFERED

The Office of Rural Health and Primary Care has scheduled seminars offering technical assistance in forming CISNs or health care cooperatives. Topics include building a network, business development, antitrust issues, provider contract issues, and the basics of community-based planning. Seminars are offered from 9 a.m. to 4:30 p.m. at the following locations: Duluth, April 19; Alexandria, April 27; Bemidji, June 8; Cottonwood, May 11 and Rochester May 12. For more information, contact Kristen Gloege at 612/282-3838.

The Monitor

MAY 1995

PRESIDENT*Andrew J.K. Smith, M.D.***CHAIR, BOARD OF TRUSTEES***Timothy J. Crinunins, M.D.***CHIEF EXECUTIVE OFFICER***Paul S. Sanders, M.D.***DIRECTOR, COMMUNICATIONS***Mark S. Vukelich***EDITOR***Lorrie Holmgren*

Chief of Professional Services

Maplewood Medical Center • Maplewood, MN

Group Health, Inc., is seeking a board certified family practice/internal medicine physician interested in pursuing an important leadership role at our Maplewood Medical Center while maintaining a clinical practice.

The chief of professional services is the physician manager of the clinic and is involved with day-to-day operations and staffing decisions while maintaining his/her clinical practice. The chief receives administrative support from the clinic manager and the Group Health administrative and physician management team.

Group Health provides many opportunities for professional growth and development. Many of our physicians conduct research funded by our

Group Health Foundation. In addition, Group Health offers its physicians competitive salaries and generous benefits including two weeks of paid time off for continuing medical education.

If you are interested in this challenging opportunity, please call Ann Mliner at (612) 883-5337, 800-472-4695 or send CV to: Group Health, Inc. A division of HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

An EO/AA Employer.



HealthPartners

Continuing Medical Education

St. Paul-Ramsey Medical Center

Fall Schedule of Courses

Mark your calendar now for these upcoming conferences:

1995

October 26-27 Trauma Management for

Primary Care Providers, St. Paul

November 16-18 Primary Care Medicine, St. Paul

December 7-9 Cardiopulmonary Medicine, St. Paul

Information and registration

Continuing Medical Education, St. Paul-Ramsey Medical Center

640 Jackson Street, St. Paul, MN 55101

Phone 612-221-3992

Fax 612-292-4773

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY



DI Coverage: Going, Going...

Most physicians carry some sort of individual disability income insurance. From medical school on, doctors are approached time and again by agents and planners of all kinds, offering to review the coverage currently in force. The trend has always been one of better policy features and more and more aggressive marketing. In short, if one company wasn't willing to give the doctor the coverage he or she desired, there were literally dozens of other companies ready to fill the void.

End of an Era

But, those days are gone. In the last two months, the noncancellable individual disability insurance industry has seen the withdrawal of four of the major carriers, and other carriers have announced major changes to the types and costs of policies offered to physicians. Poor claims experience from these companies' 1985-1989 blocks of business, and especially poor claims experience with physicians in particular, has led these companies to take the actions stated above.

What Happened to DI?

In the simplest terms, overaggressive marketing and sloppy underwriting created a situation in which companies charged unrealistically low premiums and then had to pay more in claims than they had projected. Since the true financial performance of a disability product isn't known for several years, by

the time some of these DI underwriters realized what was happening, it was too late to take corrective action. Compounding the problem in the physician marketplace was the fact that large numbers of doctors were underwritten by these companies, and doctors made large numbers of claims over the past 18 months.

So Now What?

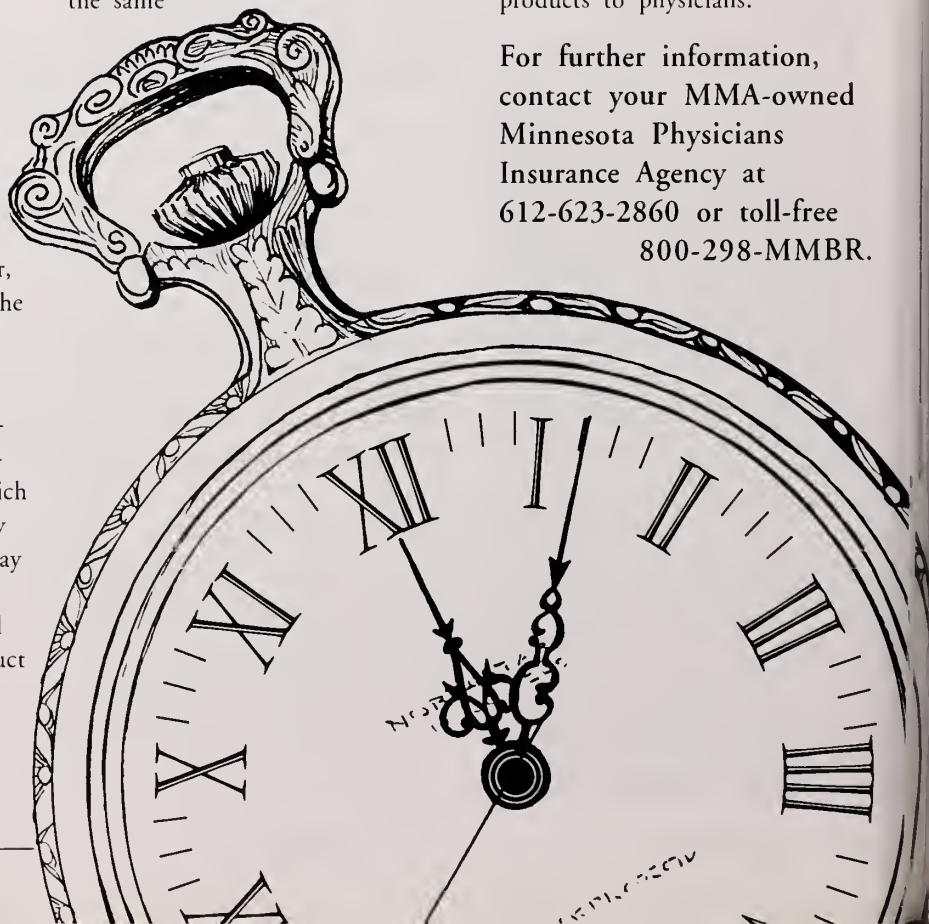
The net result is that physicians today are no longer preferred business by all carriers. And, what most doctors have now for individual disability income coverage is what they will have to stay with. There is, however, a very small window of time left for a review of that coverage, but within the next few months, the ability to purchase the same

quality DI contracts most physicians enjoy today will not be possible. Among the items that some carriers have scheduled for the chopping block are fixed premiums, "own occupation" protection, and voluntary rehabilitation benefits.

All Is Not Lost

Not all companies are pulling out of the individual disability income arena. Among the few who will remain is the MPA-endorsed carrier, Paul Revere. As the nation's leading disability carrier, Paul Revere is better situated to weather the current storm. Although experiencing some of the same difficulties as other carriers, it has managed to remain profitable while offering competitive DI products to physicians.

For further information, contact your MMA-owned Minnesota Physicians Insurance Agency at 612-623-2860 or toll-free 800-298-MMBR.



History's Answers to Medicine's Troubled Present

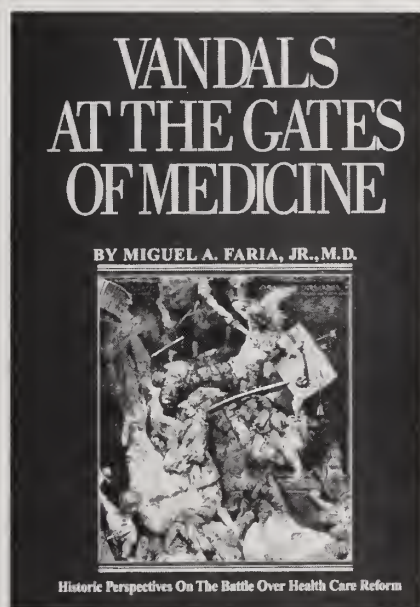
Despite its ultraconservative political digressions, "Vandals at the Gates of Medicine" by Miguel A. Faria Jr., M.D. (Hacienda Publishing, 1994) offers a provocative overview of world history and how it relates to the state of medicine today.

Seymour Handler, M.D.

Vandals at the Gates of Medicine—Historic Perspectives on the Battle Over Health Care Reform" is a comprehensive historical tome intended to relate the development of medical care over the ages with the socioeconomic problems facing physicians today. The book provides a magnificent account of the history of civilization (primarily Western civilization) from ancient times to the Renaissance, juxtaposed with the author's conservative interpretation of the lessons history holds for health reform today.

Author Miguel Faria is a Cuban émigré physician who left Castro's Cuba at age 13, early in the Communist regime, spending much of his adult life in the United States. His writing style, his vocabulary, and his intuitive sense of history suggest that, in addition to his talents as a physician, Faria is an erudite historian.

The book carries the reader from the ancient Egyptian civilization through the Renaissance in Western Europe. Particularly enlightening are Faria's descriptions of the Golden Age of Greece and the Roman Empire, as well as the Dark Ages—a frightful era devoid of medical care and replete with religious fervor. Faria shows that plague and pestilence have had a far greater effect on humans than war and conquest. The sixth century plague during the reign of Justinian in the Byzantium, for example, killed far more people than



the subsequent pestilences of the 14th and 17th centuries, predominantly involving Western Europe.

My reservations about the book relate to Faria's personal ultraconservative politics and his attempt to equate the current problems assailing physicians with the historical "vandals," the barbaric Germanic tribes that destroyed the Roman Empire. Readers of conservative political leaning may well enjoy the elitist and self-serving digressions into politics presented throughout. However, most political liberals and moderates may take offense at the author's comparisons and ominous prediction of a government takeover of medicine and all it implies.

The author compares the current problems of medical practice to the fall of the Roman Empire, thus the title, "Vandals at the Gates of Medicine." In the early centuries of the first millennium, Rome slowly converted from a participative government to a socialist system based on a central omnipotent government with an all-powerful bureaucracy. Although ostensibly designed to protect minorities, Rome deteriorated to a "mobocracy," in which the tyranny of the majority gained power. Although Rome remained militarily strong, the changes diminished its strength and ability to defend itself against the Germanic barbarians of the North (the "vandals"). Similarly, says Faria, modern medicine has lost its influence in the decisions of

government, becoming an unprotected minority, forced to bow to bureaucratic government decisions. The medical minority now is subservient to the tyranny of the majority, weakening organized medicine and permitting governmental bureaucracy to make decisions for physicians.

Today the vandals are many. Faria decries government's intrusion into medicine; for example, its oversight of credentialing, its reimbursement practices, its widespread data collecting, and its monitoring of outcomes. He maintains that physicians should have the right to charge for professional services at fair market value, emphasizing the entrepreneurial spirit of this country and pointing

out that our founding fathers never guaranteed "entitlements" and free care. Faria further criticizes the "liberal media" and special interest groups, particularly government-favored minorities, who have inherited considerable power disproportionate to their numbers. At the same time, he condemns the ability of the majority in a social democracy to abolish the individual rights of citizens in a constitutional republic. Faria also points a finger at attorneys. In his chapter on the perils of the republic, he blames the growing legal profession for the epidemic of negligence and product liability litigation.

Vandalism of the medical profession continues. Increasingly, organized medicine does not determine its destiny. Governmental bureaucracy, managed care, and reimbursement dictation combine to make physicians vassals of the state. Unless physicians organize and stake a strong position as advocates of the patient, they will fall to the vandals

and patient care will be compromised, Faria contends. Whether you agree with this argument or not, you will most likely find "Vandals" a compelling and informative overview of world history and physicians' place in it. **MM**

Seymour Handler is a pathologist with North Pathology Associates, North Memorial Medical Center, and a member of the Minnesota Medicine Advisory Committee.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. —and that's not a line, it's a *promise*.

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services

600 West 98th Street, Suite 390
Bloomington, MN 55420

612-885-6224

1-800-842-6469



LICENSED LOCUM TENENS PHYSICIANS

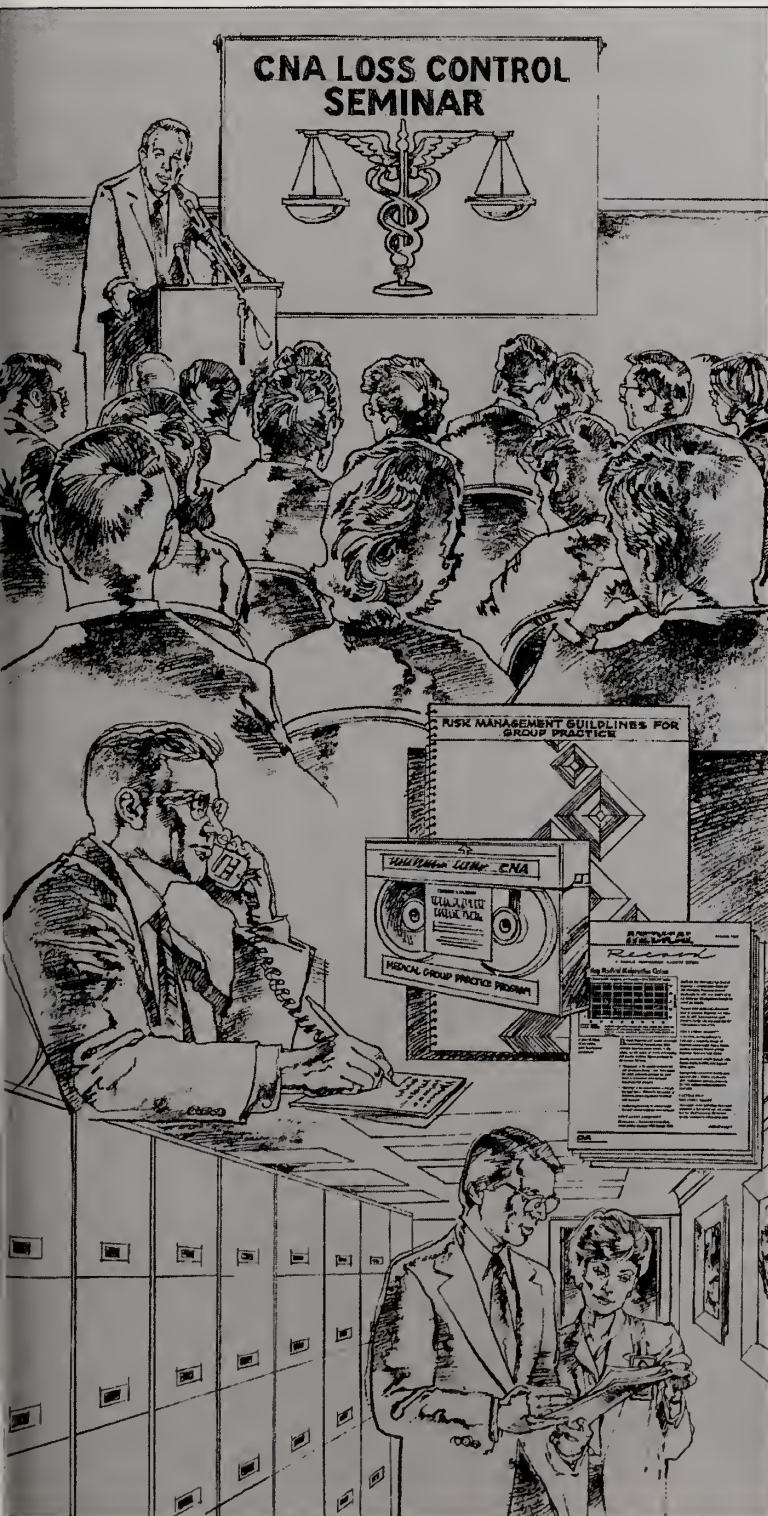
Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle-free position for some extra money?



Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
Fax: 612/682-4791

PREVENTIVE MEDICINE FROM CNA:

Risk management for the changing needs of your group practice.



At CNA, we believe that effective risk management is the cornerstone of any professional liability insurance program. That's why we have developed a broad and flexible risk management program to meet the changing needs of your medical group practice.

Our program helps protect your reputation and control your premium cost by showing you and your staff how to minimize your exposure to loss. We do this by offering regional educational seminars, video and journal reference materials, newsletters, telephone consultations and even on-site surveys. And, by attending one of our Medical Loss Control Seminars, you even receive a premium discount.

**CNA
MEDICAL
GROUP
PRACTICE
PROGRAM**

We have the expertise and resources to help your group practice now and as your needs change. For more information about medical group practice professional liability insurance from the CNA Insurance Companies, contact your local broker or:

The CNA Insurance Companies
Professional Liability Group, 19S
CNA Plaza
Chicago, IL 60685
(312) 822-5000

CNA

For All the Commitments You Make®

Program underwritten by property/casualty companies of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685. CNA is a registered service mark of the CNA Financial Corporation.



Pierre duCharme
Perham



Rick Sall
Duluth



Rich Westlund
Hutchinson



Dan Anderson
St. Cloud



Dave Westlund
Hutchinson



Joe Steck
Mankato



Scott Weilage
Mankato



Jim Erickson
Rochester

*Quality...Service...
Convenience...
from people you
can trust.*

Minnesota Physicians Insurance Agency is a statewide network of counselors uniquely dedicated to personally managing risk for physicians, their families, their clinic, and their employees. You can count on us to deliver the highest quality insurance products at the best possible price, negotiated specifically for you. We combine expertise with a level of service and convenience health care professionals like you have the right to expect. Call us at **612/623-2860** or toll free **800/298-MMBR**, and we'll send you an overview of available products.

**MINNESOTA PHYSICIAN
INSURANCE AGENCY**

A MMBR Company

*Owned by the members
of MMA and HCMS.*



Angela Ericksan
Hastings



Debra Newman
Edina



Dick Mussell
Anoka



Mike Prazich, D.D.S.
Plymouth



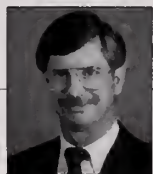
Brian Mikkelsen
Minneapolis



Wil Heupel
Minneapolis



Mark Bryant
Wayzata



Bab Andersen
Hopkins

DURENBERGER

(continued from page 7)

and doctors are rewarded for doing what they do best. That seems to be something difficult to get organized medicine to think about because physicians feel that the practice they've known is being threatened by people who don't know medicine."

In some respects, those fears are not unfounded, Durenberger says. "In today's market, the people who are the buyers of health care are trying to tell the profession that it's going to have to change." But, he asserts, "Nobody wants to tell the profession what it ought to be; that's up to the profession. Until the leaders of medicine start defining what the future is going to be, we really won't make it. So part of what I'd like to spend my time doing is alerting physicians to opportunity."

Continuing a close relationship with the Minnesota Medical Association may be one way for the former senator to share this vision with Minnesota physicians, and Durenberger is open to invitation. "Maybe through the Health Policy Institute we can do that," he says. "I guess I'm just basically waiting to be asked, in some way, for my help."

MM

IT'S TIME WE CLEAR
THE AIR...TOGETHER.

**SMOKE
FREE
2000
COALITION**

For more information please call
612-338-8193.

Physician Reviewers

Health Risk Management provides comprehensive health care quality management and information services based on our nationally recognized healthcare practice guidelines. The continuing growth of our care management business requires additional part-time consulting physicians to apply clinical expertise to patient care review. You will work within your medical specialty field to provide care review services and serve as an educational resource to our clinical staff.

We are seeking physicians with backgrounds in:

- INTERNAL MEDICINE
- GENERAL SURGERY
- ORTHOPEDICS
- NEUROLOGY
- CARDIOLOGY
- FAMILY PRACTICE

To qualify, you must be actively licensed and board certified, have related experience, and knowledge of managed health care.

We offer:

- Competitive pay
- Opportunity to complement your expertise
- Flexible part-time schedules including day, evening and on-call night shifts on weekdays and weekends

Medical professionals interested in helping shape the future of health care should send CV to Human Resources, fax (612) 829-3664 or call 829-3540 for more information: Health Risk Management, 8000 West 78th Street, M.S. 8-210, Minneapolis, MN 55439. EOE.

HRM®

CAPITATION

(continued from page 9)

giving away services for free.

THE CONTRACT

A medical practice must consider a number of issues when developing a capitation contract. First, the services covered and not covered should be specified in as much detail as possible, referencing the enrollee benefit contract. Second, the capitation preferably should be a specific dollar amount rather than a percentage of premium, unless the group has a role in setting premiums. This will protect the group against HMO price wars. The dollar amount of the capitation should be sufficient to cover all expenses projected under the contract and to reward the group for its services at the equivalent of 100 percent of billed charges plus an additional amount for case management.

The contract should carefully define enrollee eligibility and should provide a mechanism for retroactive

enrollment and termination of eligibility that does not compromise the group's ability to manage risk. Performance standards for maintenance, for reporting of eligibility lists, and for timeliness and accuracy of claims processing by the health plan should be guaranteed in the contract and should be verifiable by the group—that is, the group should have access to the supporting data for audit purposes.

The group under capitation may choose to manage risk by developing subcapitation contracts for hospital services, specialty services, or such ancillary services as laboratory work. The group can further reduce its risk by purchasing stop-loss insurance for catastrophic cases.

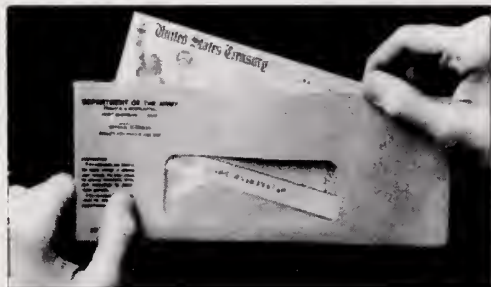
When properly constructed, a capitation arrangement between a health plan and a medical group can be both financially sound and professionally satisfying to the physician.

MM

David Pautz is an internist with Aspen Medical Group in Minneapolis.

SURGEONS: COULD YOU USE AN EXTRA \$10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of \$10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



You will have opportunities to continue your education and attend conferences, and we will be flexible about scheduling the time you serve. Your immediate commitment could be as little as two weeks a year, with a small added obligation later on.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Medical Counselor.

**CALL COLLECT CPT. RICK OTTO
612-854-7702**

**ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®**

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 260 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice for the Region
- Orthopaedics - Detroit Lakes, Bemidji
- General Surgery - Wahpeton
- Pediatrics - Bemidji
- OB/GYN
- Urgent Care



For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010



MeritCare Medical Group
737 Broadway • Fargo, ND 58123



People and Places Making Medical News

People

Hungary Honors Minnesota Pediatrician

Robert O. Fisch, M.D., received an honorary doctoral degree from the Hungarian Pediatric Association in Budapest in March. Fisch, who was recognized for his work in phenylketonuria, is a professor in the Department of Pediatrics at the University of Minnesota and a staff member of the Pediatric Department at St. Paul-Ramsey Medical Center. The award was particularly meaningful and somewhat ironic for Fisch, who in 1956 fled Hungary because of its oppressive government.

Fisch was liberated from the Gunzkirchen Concentration Camp in Austria 50 years ago this month.

'U' Ob/Gyn President

Robert A. Nordland, M.D., was recently elected to serve a three-year term as president of the clinical faculty for the University of Minnesota's Department of Obstetrics and Gynecology. Nordland, an obstetrics and gynecology specialist with Western OB/GYN Ltd., has provided medical services in the Twin Cities metro area for nearly 20 years. He has offices in Waconia, Shakopee, Chanhassen, Mound, and Maple Plain. The university's clinical faculty provides medical students with practical, hands-on learning experiences.

Clinical Endocrinology Group President

Stephen F. Hodgson, M.D., of Rochester, Minnesota, was nominated president of the American Association of Clinical Endocrinologists (AACE) at the group's April 1995 annual meeting in Chicago.

Hodgson is a professor in the Department of Internal Medicine,

Division of Endocrinology, at the Mayo Clinic and Mayo Foundation in Rochester. He is also a former chair of the Bone and Mineral Disease Clinic and director of the Bone Histomorphometry Laboratory at Mayo. He will succeed **Stanley Feld, M.D.**, of Dallas, who will remain on the board of directors as immediate past president.

AACE is a professional medical association dedicated to clinical endocrinology and has more than 2,000 members.

Local NBME Committee Member

The National Board of Medical Examiners appointed **Melvin E. Sigel, M.D.**, to serve a three-year term on the STEP 2 Test Committee of the United States Medical Licensing Examination. Sigel practices at Minneapolis Ear, Nose & Throat Clinic, P.A.

Fuld Fellowship for Nursing Students

Lisa M. Sherwin of St. Olaf College in Northfield, Minnesota, is one of 52 outstanding nursing students selected as Fuld Fellows from a group of 400 top students nominated by deans and directors of nursing schools in the United States.

The Fuld Fellowship program includes a 14-day study tour in July with a visit to Edinburgh, Scotland, to attend a four-day conference on Holistic Health Care hosted by the Scottish Highlands Center for Human Caring. Program participants are expected to share their experiences with fellow students and faculty.

The Fuld Fellowship was established in 1986 to promote the awareness that nursing is an international profession.

HealthEast Staff

HealthEast appointed **Corey Hobbins** project manager of its

Caring Touch Design Team, which will explore better ways to meet the needs of patients and their families. "Our challenge is to design a system where patients and their needs always come first," Hobbins says.

Hobbins was senior director of Social Services at HealthEast for the past six years. Before that she was director of Social Services and gerontology at Riverside Medical Center (now Fairview Riverside and St. Mary's hospitals).

Joe Clubb is HealthEast's new senior director of Social Services. He joins HealthEast after three and one-half years as director of Social Work Services at Fairview Southdale Hospital.

Medical Alley Awards

Medical Alley presented eight awards to individuals and companies for outstanding achievement and contribution at its 10th annual awards banquet in March.

John H. Kersey, M.D., a professor in the Department of Laboratory Medicine and Pathology at the University of Minnesota, received Medical Alley's Lifetime Achievement Award.

Recipients of other awards are: **Roger S. Mazze, Ph.D.**, senior vice president, and **Ellie Strock, R.N.**, chief administrator, members of the Staged Diabetes Management Team, Park Nicollet Medical Foundation, for their outstanding contribution in research and development; **K. James Ehlen, M.D.**, president, Allina Health System, for outstanding contribution by a third-party payer or employer; **3M Health Care** for outstanding achievement in health care manufacturing; **Herbert F. Polesky, M.D.**, director, Memorial Blood Center of Minneapolis, for outstanding achievement in health care delivery; **Edward J. Black**,

Pioneer Health Systems, for outstanding contribution to the health care industry; the Honorable Roger Cooper, Minnesota House of Representatives, for meritorious service in government; and Audrey Adams, SIMS Deltec, for meritorious service to Medical Alley.

Medical Alley, located in St. Louis Park, is the trade association for Minnesota's health care industry, which includes more than 500 companies in the state.

Places

Medtronic Gains FDA Approval to Market Defibrillator

Medtronic in March obtained approval from the Food and Drug Administration to market five models of its newest defibrillator referred to as the "Jewel."

The battery-powered defibrillator is used to control tachyarrhythmia and is the first system small enough to be implanted near the pectoral muscles.

Financial analysts say approval of the Jewel puts Medtronic in a clear advantage over its main competitor, California-based Ventritex, which will probably have the FDA's approval to market a similar device by early 1996.

Previous implantable defibrillators available in the United States required two or more incisions in the abdomen to be implanted, more complicated surgery, and high costs. However, the Jewel is small enough to be implanted with a single incision near the collarbone.

"The FDA approval of the defibrillator is significant since it represents the first in a 'tremendous pipeline' of tachyarrhythmia products for Medtronic," said Arch Smith, a Piper Jaffray analyst in a Minneapolis-based *Star Tribune* article.

According to Medtronic officials, studies have shown that the easier implantation could reduce hospital and other costs by more than 30 percent.

Socioeconomics

State HMOs Earn \$51 Million Profit in 1994

Minnesota's eight HMOs earned \$51 million in profit on \$2.55 billion in revenues in 1994, according to the Metropolitan Council of HMOs. The figure would have been higher but the value of Medica's reserves dropped \$15.3 million, primarily because of losses on the value of government securities and on derivatives, according to Stanley Hamilton, the company's chief financial officer, as reported in the Minneapolis-based *Star Tribune*. Those losses were offset by a \$19.3 million contribution to reserves.

HMO premiums increased an average of 4.9 percent in 1994, down from 8.6 percent in 1993. HealthPartners' premiums increased an average of 6.7 percent based on HMO business, not on the management services it provides to self-insured programs. Medica's average increase was 4.7 percent, but its calculation covers all business, including both HMO and self-insured plans.

Minnesota HMO Executive Salaries Lower than National Average

HealthPartners chief executive officer, George Halvorson, was paid \$383,515 in 1994, the highest reported salary of HMO executives in Minnesota, according to reports provided to the Minnesota Department of Health.

K. James Ehlen, former chief executive of Medica, received the top salary in the past few years, but he is now president of Medica's parent organization, Allina, and his salary is no longer reported to the Health Department. Medica's new executive officer, David Strand, was paid \$305,349 in 1994. Halvorson's and Strand's salaries are lower than the national average—\$532,000 for CEOs at managed care companies with revenues above \$750 million—according to J. Richard & Co., a

national consulting firm. Minnesota's HMOs are by law nonprofit, one reason for the lower salaries. Another reason is that Minnesota HMOs tend to promote from within, rarely recruiting officers from out of state.

HealthPartners to Offer Computerized Database

HealthPartners has developed a computerized database that will help customers compare and choose physicians based on service and performance criteria. The system will be available at the offices of some major clients, at clinic offices, at a public place like the Mall of America, and maybe on Internet, starting in August.

"If we do this right, we'll redefine the process of selecting a physician or clinic," said George Halvorson, HealthPartners' chief executive officer, in a Minneapolis-based *Star Tribune* article. "The idea started several years ago when we noticed significant variances in quality and service among clinics and consumers didn't know anything about them." Halvorson has said he believes that if consumers have the needed information to make decisions, clinics will work to improve quality and lower cost to attract patients.

A demo version of the program allows users to find, for example, clinics that offer weekend or evening hours, urgent care availability, or access to a bus line. After identifying a clinic, the program lists its physicians with information about their medical degrees, certifications, foreign language abilities, and other characteristics. The system can then play a recording of the physician's voice as the user reviews specialties and interests, while an electronic photo of the doctor is shown on the screen. In addition, the consumer can obtain information on how the clinic has been rated in customer surveys for such things as waiting time for an appointment and promptness in answering the telephone, as well as information on how well a clinic



Family Practice

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 155 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

EXPERTISE

Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.

NORWEST

To The Nth Degree®

Minneapolis 667-0705
©1995 Norwest Bank Minnesota N.A.
Member FDIC

has performed on various health outcomes measures, such as mammography and immunization rates. It does not include satisfaction or performance measures for individual doctors because HealthPartners emphasizes a team approach to medical care. The system will also help patients locate clinics or physicians that specialize in treating certain medical conditions, such as asthma, allergies, back pain, cancer, diabetes, heart disease, and HIV infection.

Low-Income Twin Citians Seek More Hospital Care

Twin Citians from low-income areas are four times as likely as people from high-income areas to be hospitalized for ailments typically treated in the outpatient setting, such as asthma, diabetes, and severe skin infections, according to a Metropolitan Healthcare Council study. In addition, when hospitalized, they are more likely to be admitted through emergency departments.

The council concluded that many of the hospitalizations could be avoided if the patients received effective, timely, and continuous health care for their conditions. The study showed that a slightly higher percentage of the patients unnecessarily hospitalized for these conditions were uninsured (5.5 percent) compared with the percentage of uninsured among all hospitalized patients (3.9 percent). In addition to lack of health insurance, the researchers attributed the higher hospitalization rates to chemical dependency, mental health problems, and lack of a regular primary health care provider.

Blue Cross, Mankato Clinic Forming Joint Venture

Blue Cross and Blue Shield of Minnesota and the Mankato Clinic have announced plans to form a joint venture. Under the 50-50 partnership, the Mankato Clinic and BCBSM will retain their

autonomy but will work together to form a health care delivery system in the Mankato area in south-central Minnesota. The joint venture will be governed by a board of directors with equal representation from both partners. The partners will cut costs by streamlining administration and business systems and developing innovative health plan products to meet local residents' needs.

BCBSM has already formed similar joint ventures with clinics in the Fargo-Moorhead and Willmar areas and has said it intends to form other agreements throughout the state.

Mesabi Regional Medical Center, Mesaba Clinic Join 'U' Health System

The Mesabi Regional Medical Center in Hibbing became a wholly owned subsidiary of the University of Minnesota Health System in early April, and the Mesaba Clinic became affiliated with UMHS. The

175-bed medical center employs 520 staff members, and the 102-employee clinic serves about 50,000 patients. UMHS plans to work with the Center for Rural Health to recruit physicians, including specialists and subspecialists, to the Mesaba Clinic.

The most immediate change for Mesabi Regional Medical Center will be construction of a \$3 million radiation therapy center for cancer treatment and a \$2 million expansion of existing facilities and programs, both scheduled to begin this spring. UMHS will provide up to \$2 million for the planning, creation, and implementation of an Iron Range-wide integrated health care system and guarantee \$9 million in debt for MRMC.

"Having a physical presence on the Iron Range will make it easier to bring health care innovation from the university to the residents of northeastern Minnesota," said Greg Hart, UMHS president, adding that the new arrangement strengthens the university's ties with the region. MRMC and the university have been affiliated since 1987, and university specialists see patients there weekly.

MRMC will remain a separate entity with its own employees and board of directors, consisting of six community members, the president of the Mesaba Clinic, the section head for the Duluth-Adams Clinic, one independent physician, and four UMHS representatives.

The new 8,000 square-foot radiation therapy center, which will be attached to the main medical center, is expected to open in late 1995. It will treat approximately 250 patients per year and will employ five full-time staff. Half the center's cost will go toward the purchase of state-of-the-art medical equipment for cancer treatment, including a linear accelerator.

Minnesota BMP Disciplines Fewer Physicians

The Minnesota Board of Medical Practice disciplined 94 physicians

in 1994, down from 104 in fiscal 1993, according to Leonard Boche, BMP executive director. The number of complaints was also down: 1,061 complaints in fiscal year 1994, compared with 1,254 in fiscal 1993. "That's contrary to the long-term trend, which we cannot explain," said Boche.

Nationally, 3,685 physicians were disciplined for misconduct and other problems in 1994, an increase of 11.8 percent over the previous year. The number has climbed nearly 40 percent over three years, according to the Federation of State Medical Boards.

Law & Policy

Judge Upholds Marshfield Clinic Monopoly Verdict

A federal judge in Madison, Wisconsin, upheld the verdict holding the Marshfield Clinic guilty of creating a health care monopoly in northern and central Wisconsin, while simultaneously reducing the damages awarded to Blue Cross and Blue Shield of Wisconsin, the plaintiff in the case, from \$16.1 million to \$5.6 million. (Because damages are tripled in antitrust cases, the amount Marshfield Clinic will actually be required to pay will be about \$17 million rather than the originally awarded \$48.5 million.)

The final order by U.S. District Judge John C. Shabaz also requires the clinic to allow its doctors to do business with other HMOs. However, it held that Marshfield Clinic would not be required to divest itself of its satellite practices.

In January, the Marshfield Clinic was ordered to pay the original amount when a jury decided that the Marshfield Clinic created a health care monopoly, fixed prices, drove independent doctors from the region, and excluded competing health maintenance organizations from the market. Announcing his final order, Judge Shabaz called the original jury award "monstrously

excessive," reducing the total award to about \$17 million.

According to Reed Hall, general counsel for the Marshfield Clinic, clinic officials are extremely pleased with the ruling but will probably appeal certain aspects of the decision. Each party has the right to appeal the decision to the Federal Court of Appeals within 30 days.

High Court Declines to Hear Domestic-Partners Ordinance Appeal

The Minnesota Supreme Court decided in early April not to consider Minneapolis's appeal on a lower court's ruling that defeated the city's domestic-partners ordinance. The ordinance would have allowed the city to provide health insurance benefits for public employees' same-sex partners. City officials said they may ask the Legislature to change the laws so as to allow for such benefits.

"I am particularly dismayed that the court did not indicate why it decided as it did or which of our legal arguments have merit and which do not," said Minneapolis Mayor Sharon Sayles Belton in a news release. "This leaves us with no guidance regarding the authority of the city of Minneapolis to govern itself under the state home-rule statute and in this case determine what health benefits it chooses to give its own employees."

Rates, Trends, Data

Minnesotans Have 50 Percent Lifetime Cancer Risk

Of 1,000 Minnesotans, 520 will develop cancer in their lifetime, according to the Minnesota Department of Health's Minnesota Cancer Surveillance System, which collected cancer incidence data from 1988 to 1992. The risk is 15 percent higher for men than for women, primarily because of prostate cancer, which accounts for 39 percent of the total expected cancers in men.

The overall cancer rate for

Minnesota men is 3 percent higher than the national average for men, but the rate for Minnesota women is 2 percent lower than the national average for women.

The Department of Health found that 60.5 percent of male Minnesotans and 44.8 percent of female Minnesotans born today will develop cancer during their lifetimes. Breast cancer is the most common cancer among Minnesota women, accounting for 31 percent of the expected cancers.

Medical Research

Non-Herbal Tea and Garlic May Cut Women's Cancer Risk

Two studies at the University of Minnesota bolster the argument that the foods we eat can reduce our cancer risk. The first study shows that women who drink at least one cup of non-herbal tea a day reduce their risk of developing cancer of the mouth, esophagus, stomach, kidneys, and bladder by

about 50 percent compared with women who almost never drink tea. One theory is that compounds in the tea block the production of some cancer-causing agents in the body, said Wei Zheng, assistant professor of epidemiology and the study's principal author.

The study included 42,000 postmenopausal Iowa women who were between ages 55 and 69 in 1986, when they were asked to list their daily food consumption, including such beverages as coffee and tea. A follow-up survey of the women in 1993 found 2,576 cases of nonskin cancer had been diagnosed between 1986 and 1992. The 50 percent reduction in cancer was calculated after making adjustments for practices that may adversely affect cancer rates, such as smoking, as well as practices that may reduce cancer rates, such as eating vegetables and exercising. Zheng presented the study at the 86th annual meeting of the American Association for Cancer Research in Toronto.

The second study provides evidence that garlic reduces the risk of colon cancer in women—by 30 percent for those who eat garlic at least once a week, according to Lawrence Kushi, a University of Minnesota researcher involved in the study of diet and colon cancer. The results are based on a study of the same group of Iowa women, who filled out a 127-item food questionnaire and then were monitored for cancer for five years.

Kushi, associate professor of epidemiology, said the anticancer effect may be from allium, a compound also found in onions, leeks, scallions, and chives. The study questionnaire didn't include these other vegetables, so it didn't show whether they could be related to the lower risk of cancer. They have now been added to the questionnaire.

In a critique of the university's study, researchers from the National Cancer Institute's Division of Cancer Prevention and Control warned against concluding that

AIM HIGH

CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle, quality practice
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Call

**USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF**



Emergency Medicine Physician

Minnesota, Brainerd:

Opportunities for 2 BC/BP primary care or E.M. physicians to work in growing medical community; most secondary and some tertiary capabilities with good primary care base and core group of quality E.D. physicians. Moderate volume (18,000 visits per year) 162 bed rural referral center — good EMS. Quality lifestyle with excellent schools, friendly people and very good housing values in "God's country" — clean air, lakes, pines and an abundance of recreational opportunities — two hour drive to Minneapolis - St. Paul. Competitive compensation and benefits. Director position available for qualified/experienced candidate.

Send CV or call:

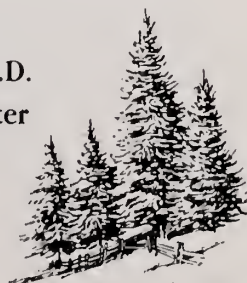
Nicholas Bernier, M.D.

St. Joseph's Medical Center

523 North 3rd Street

Brainerd, MN 56401

(218) 828-7657



garlic alone produced the lower rate of colon cancer in the study. Garlic intake may have been related to another factor, "such as more attention to food preparation, increased use of fresh foods, or home cooking," NCI argued.

Apple-Shaped Body, Sedentary Lifestyle High Risk for Heart Attack

In a 2½-year study, nearly 80 percent of Minnesotans who experienced heart attack or angina before age 55 had sedentary lifestyles and apple-shaped bodies, risk factors more prevalent in the study population than smoking, high blood pressure, and elevated cholesterol. Researchers from the Minneapolis Heart Institute Foundation presented the findings, which were gleaned from its registry for young coronary patients, at the American College of Cardiology Conference in New Orleans in March.

The good news, said Kevin Graham, director of preventive cardiology at the institute, is that "both risk factors can be modified with regular exercise, such as walking."

The results are based on the records of more than 1,000 heart patients under 55 who were treated at Abbott Northwestern Hospital in Minneapolis. Seventy-five percent of the men and 86 percent of the women were physically inactive, and 78 percent of the men and 75 percent of the women were apple-shaped (waists larger than hips). The average age of the patients was 49.

The most common occupations were law enforcement and truck driving. "It's understandable," said Graham in a Minneapolis-based *Star Tribune* article. "Both are sedentary, policemen and truck drivers tend to eat fatty foods, and both are under considerable pressure." The institute plans to work with trade unions and other groups to get the message to their members.

Study Pinpoints Risk Factors for Broken Hip

A study of 9,600 white women over age 65 found that exercising regularly, giving up coffee, correcting visual impairment, and not using certain drugs, such as Valium and anticonvulsants, should help reduce women's risk for breaking their hips, according to Kristine Ensrud, M.D., M.P.H., of the University of Minnesota, a principal researcher in the study.

During the study, which is reported in the March 23 *New England Journal of Medicine*, 192 women experienced hip fractures. The study found that women with five or more of 17 risk factors have the greatest chance of breaking a hip. Women whose mothers had broken a hip had twice the average risk of breaking a hip, making this one of the strongest risk factors in the study.

Some oft-cited factors that researchers say did not increase risk were hair color, ethnic ancestry, the number of children breast-fed, timing of menopause, whether a woman was a former smoker, and whether she had ever had cataracts. Calcium consumption also did not seem to affect risk. Smoking itself was not a risk factor but appeared to be because smokers are generally thinner, less healthy, less active, and weaker than average. The study found that the more fat women carry, the less their chance of breaking a hip; however, obesity increases the risk of heart disease, diabetes, and some forms of cancer.

Some Women Still Balk at Preventive Exams

A study of 1,019 women in southeastern Minnesota showed that more than half of them do not wish to receive reminders when it is time to have a Pap test, a clinical breast exam, or a mammogram, according to an article in the April 12 *Journal of the American Medical Association*.

Thomas E. Kottke, M.D., and colleagues from the Mayo Clinic and Foundation conducted the

study hoping to determine women's receptivity to receiving regular reminders when it is time for these tests and to determine the rates at which women underwent the tests. Kottke released the study at an AMA media briefing highlighting last month's Health Promotion and Disease Prevention issue of *JAMA*.

In the study, 89 percent of the women reported having a Pap test in the last three years. Of those women over age 40, 74 percent reported having a clinical breast exam in the past two years, and 62 percent reported having a mammogram in the past two years.

The study says, "The women seem to fall into three groups with respect to their attitudes about screening." The first group, about 40 percent to 50 percent of the population, told surveyors they will accept screening tests and want to be reminded when they are due for their tests. The second group, about 7 percent to 10 percent of the population, told them they would refuse screening even if told it was necessary. The third group, 40 percent to 50 percent of the women, told surveyors they would submit to screening if advised to have it, but they did not want to receive this advice.

According to the researchers, physicians say patient noncompliance and lack of interest lead them not to order these tests. However, the women cite physician failure to order the tests as one reason they don't have these tests. Twenty-three percent of the participants reported they are contacted by their physicians when it is time for a Pap test; 15 percent are reminded when it is time for a clinical breast exam; and 18 percent are contacted when they are due for their mammograms.

Demographic information showed that women over age 60 in the random sampling were the least likely to meet the Pap test frequency recommendation. Women over 79 were the least likely to follow the clinical breast exam and mammogram frequency recommendations. **MM**

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Pediatrics
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS

Community-based health care project positions.

Uganda: Volunteer Administrator; Kenya: Volunteer Public Health Educator, Volunteer Deputy Director; Nicaragua: Country Director (staff), Volunteer Community Organizer, Volunteer Public Health Educator.



CV/CL to:
MIHV
122 W. Franklin Ave. #110
Mpls., MN 55404
Fax 612-871-8775.

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care - at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

M A Y 1 9 9 5

May 5-6 **Annual Ophthalmology Course** University of Minnesota Continuing Medical Education; Park Inn, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 6 **A Current Update on Evaluation and Treatment of Infertility** Minnesota Urological Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

May 8-12 **Sixteenth Annual Practice of Internal Medicine** Mayo Foundation; Mayo Foundation, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 9 **Gynecology & Gynecologic Oncology** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 10-12 **Current Concepts in Radiation Therapy** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 18-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

May 18-20 **Temporal Bone Dissection** University of Minnesota Continuing Medical Education; Phillips Wangenstein Building, University of Minnesota, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

May 19-20 **Phonosurgery: Indications and Techniques** Hennepin County Medical Center/Hennepin Faculty Associates; Hennepin County Medical Center, Minneapolis, MN.

CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

May 20-21 **First Annual Minnesota Vascular Diseases Symposium** University of Minnesota Continuing Medical Education; Northland Inn, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

J U N E 1 9 9 5

June 1 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 1-3 **Clinical Hypnosis** University of Minnesota Continuing Medical Education; Sheraton Inn Midway, St.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

M A Y 1 9 9 5

May 31 **Emerging Infections** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

S E P T E M B E R 1 9 9 5

Sept. 22-23 **The Child With Unusual Infections** University of Minnesota Continuing Medical Education; Park Inn, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

O C T O B E R 1 9 9 5

Oct. 7 **Surgical Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Paul, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

June 14-16 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

June 16 **Fifth Annual Family Practice Conference** Duluth Clinic; Fitger's Theatre of the North, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

June 20-24 **Mayo Internal Medicine Eurodate 1995** Mayo Foundation/Vienna Medical Association; Vienna, Austria. CONTACT: Kay Kenitz, Mayo Foundation, Section of International Education, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

June 26-28 **Advances in Breast and Cancer Surgery** University of Minnesota Continuing Medical Education; University of Minnesota, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JULY 1995

July 22 **Anatomy and Arthroscopy** American Association of Clinical Anatomists and the Mayo Foundation; Mayo Medical Center, Rochester, MN. CONTACT: Barbara Porter, Mayo Foundation, Continuing Medical Education, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-0026.

AUGUST 1995

Aug. 18-19 **Advanced Life Support in Obstetrics** Hennepin County Medical Center/Hennepin Faculty Associates; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

Aug. 27-30 **Minneapolis Transplant Congress: New Immunosuppressive Drugs** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

SEPTEMBER 1995

Sept. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 12 **Molecular Biology for Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 13-15 **Principles of Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 14-17 **Mechanical Ventilation: Principles and Applications** University of Minnesota Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 16 **Endorectal Ultrasonography** University of Minnesota Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 22-23 **Nursing Home Medical Directors** University of Minnesota Continuing Medical Education; Sheraton Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

College Health Physician:

Student Health Services at Mankato State University seeks a physician to provide outpatient medical care for diverse student population in a comprehensive outpatient center that offers general medical care, laboratory and x-ray services to adolescent and adult students. Health education is a major focus. BC, preferably family practice or internal medicine. Minnesota license eligible. Academic year (nine-month) appointment plus one five-week summer session. No evening or weekend call. Excellent benefits.

Send application letter, CV, and names, addresses, and phone numbers of three references to Donald H. Craig, Ph.D., Director of Counseling and Health Services, PO Box 8400, MSU #21, Mankato, MN 56002; 507/389-5237 MSU, a comprehensive university of 13,000 students located 80 miles south of Minneapolis/St. Paul, is actively seeking faculty and staff that will enrich its cultural, racial, and ethnic communities.



Family Practice

Minnesota, Pine River:

Lakes, pines and quality lifestyle.

Join 1 full time and 2 part-time FPs in beautiful rural area — call share with group of FPs in larger multispecialty clinic in Brainerd. Primary outpatient practice with good support. Affiliation with Brainerd Medical Center (30+ physician multispecialty group) and St. Joseph's Medical Center (162 bed rural referral center/secondary hospital with 60 active physicians).

Send CV or call:

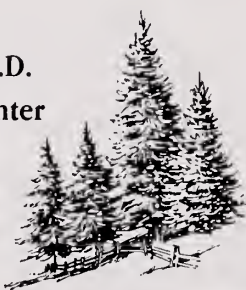
Nicholas Bernier, M.D.

St. Joseph's Medical Center

523 North 3rd Street

Brainerd, MN 56401

(218) 828-7657



Columbia Park Medical Group

- Family Practice ● Internal Medicine
- Occupational Medicine
- BC/BE Specialists

FAMILY PRACTICE: Join Group or do Locum Tenens Join 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Seven-member Department has busy hospital and clinic practice.

OCCUPATIONAL MEDICINE: Five B.C. physicians looking for additional physician to join busy Occupational Health Department.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group

6401 University Avenue N.E., #200

Fridley, Minnesota 55432

Kay Duffney
(612) 586-5876

Group Health, Inc. Associate Medical Director Quality and Utilization Management

Group Health, Inc. is the staff division within HealthPartners. As one of the largest health care organizations in Minnesota, HealthPartners provides health care coverage and services to more than 630,000 members. Group Health has 300 physicians on staff and serves 250,000 members.

We are currently seeking an Associate Medical Director, Quality and Utilization Management to support the Medical Director of our Staff Division in promoting the principles and guiding the integration of Quality Improvement throughout the health care delivery system.

The Associate Medical Director will provide leadership for quality and utilization activities; participate in quality utilization and consulting activities; support integration efforts of QUM programs throughout all of HealthPartners.

Job requirements include Board Certification, five years full-time experience in clinical practice and a formal education management and proven managerial track record; management experience with a plan for formal education can substitute for formal education. Also required, is knowledge and experience in QUM and managed care principles and excellent communication skills.

We offer a competitive salary and comprehensive benefits package. For consideration or more information, please call Ann Mliner at (612) 883-5337, 800-472-4695 or send CV to: HealthPartners, 8100 34th Ave. South, P.O. Box 1300 Minneapolis, MN 55440-1309. Fax (612) 883-5395.



The HealthPartners family of health plans and health-related companies include Group Health, MedCenters and Ramsey. EO/AA Employer.



HealthPartners

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., May 15 for July ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Family Practice, Ob/Gyn, Internal Medicine, Physician Assistant to join progressive 11-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact: Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*5/94-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd. is seeking additional BC/BE physicians in the following specialties: orthopedics, radiology, invasive cardiology, oncology/hematology, family practice, and general internal medicine. The Mankato Clinic is a 59-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. M. P. Wheeler, President, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (10/93-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician,

multispecialty practice located just south of the Twin Cities on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

La Crosse, Wisconsin

BC/BE general pediatrician to join four pediatricians in growing multispecialty group (70 physicians). Competitive guaranteed income/benefits. Affiliation with local hospital system and major medical center expected. Desirable midwestern, small city in beautiful Mississippi River Valley. Great family atmosphere, excellent schools and recreation opportunities.

Send CV to:

P. Stephen Shultz, M.D.
SKEMP CLINIC
800 West Avenue South
La Crosse, WI 54601
Fax (608) 791-9898 or
Phone (608) 791-9844, Ext. 6329

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/ Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Donald Weinshenker, M.D.
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.

Community Clinic providing neighborhood-based health care is seeking physician to compliment current staff of MDs, mid-level practitioners, health education and mental health professionals. Candidates should be BC/BE in internal medicine or family practice. Full time or part time, we're flexible! Serve diverse populations. Call or write Nancy Briggs, Executive Director, North End Medical Center, 135 Manitoba Avenue, St. Paul, MN 55117; 612/489-8021. *2-5/95

Family Physician to join the medical staff of five family practitioners in a well-established growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Excellent subspecialty support, progressive community hospital, diverse patient population. Guaranteed fringe benefits program with a payback program. Call collect, 612/532-3154, or write Frederick W. Haack, Administrator, Mille Lacs Health System, PO Box A, Onamia, MN, 56359. *6-9/95

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. 3-6/95

Just minutes from your back door and you're into some of the only real, NATURAL wilderness areas remaining in America.

Isn't it time to get away?

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park—two natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd., a 30-physician, multi-specialty clinic, currently has openings in **family practice, internal medicine and orthopedics**. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:
Bill Doran, Physician Recruiter
910 Sixth Avenue North
Virginia, MN 55792
1-800-377-3290 or
218-741-0150

East Range Clinics LTD 

PHYSICIAN WANTED

Community Care for the Elderly is looking for a board certified internist or family practitioner with an interest in the care of the elderly. The position offers a position to care for the frail elderly of the community in an adult health care center and clinic. An understanding of the elderly and the ability to work with a multidisciplinary team is needed. The positions available are for part-time and full-time practice. Interested individuals should contact:

Mary Gavinski, M.D., Medical Director
Community Care for the Elderly
5228 W. Fond du Lac Avenue
Milwaukee, WI 53216
414-536-2110, ext. 254

NURSES!

**ENHANCE YOUR CAREER ★ BECOME A NAVAL RESERVE NURSE
\$18,000-\$30,000 BONUSES**

Motivated nurses around the United States are enhancing their leadership skills by joining the Naval Reserve Health Care Team. Through this flexible, part-time opportunity you can experience the pride and prestige of being a Naval officer. Serve your country with other medical professionals while you receive training in military medicine. If qualified, you may be eligible



You and the Naval Reserve.
Full Speed Ahead.

for a \$6,000 to \$10,000 yearly bonus for three years in addition to a competitive pay and retirement package. Other benefits include financial assistance for advanced nursing education, worldwide travel opportunities, shopping at military stores, and full-time term life insurance.

If you would like to know more about wearing the gold of a Naval Reserve nurse, call:

1-800-633-3209

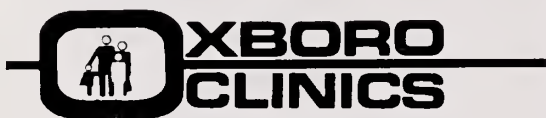
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office
Fairview Clinic Services

600 West 98th Street, Suite 390
Bloomington, MN 55420
(612) 885-6224 or toll free 1-800-842-6469

Family Practice/General Surgeon/Pediatrician, BC/BE, to join progressive 26-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., or Scott D. Ellingson, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EEO. *3-5/95

Family Practice—North St. Paul, Minnesota: Family practice group of four seeks to fill vacancy. Full range of family practice with ob/pediatrics/geriatrics. Stable community clinic since 1946 with excellent growing patient population. Hospital affiliation is St. John's Northeast and Health-East facilities. Opportunity for one-year salaried position with subsequent by-in to partnership. Clinic is associated with East Metro Health Organization with multiple insurance contracts. Contact Marty Dennison, M.D., 2579 East Seventh Avenue, North St. Paul, MN 55109; 612/777-7414. *3-6/95

St. Paul, Minnesota: BC/BE family physician to join a small suburban branch office of Ramsey Clinic—a 215-physician multispecialty group with affiliations with Health-Partners and St. Paul-Ramsey Medical Center—a regional tertiary care facility. The Maplewood office is a six-

URGENT CARE D E P A R T M E N T

- BC/BE Family Practitioners, General Internists, or Emergency Medicine Practitioners
- Three positions available; nine positions filled
- Varied and challenging patient population
- New flexible scheduling options, all considered full time with same base pay:
 - #1 40 hrs/wk, no evenings/no weekends
 - #2 36 hrs/wk, 6 hrs of evenings/weekends
 - #3 32 hrs/wk, 12 hrs of evenings/weekends
 - #4 28 hrs/wk, 18 hrs of evenings/weekends
- A 385 - Physician Multispecialty Clinic

Contact Patrick Moylan at 612-932-5986
or Send CV and letters of inquiry to:
Physician Recruitment
Park Nicollet Medical Center
3800 Park Nicollet Blvd.
Minneapolis, MN 55416
or FAX 612-932-6490



Park Nicollet Medical Center
A HealthSystem Minnesota™ member

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Family Practice	Pediatrics
Internal Medicine	Neurology
Orthopedic Surgery	OB/GYN
Noninvasive Cardiology	Urology

Send your CV to Gary Luiten, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/862-9012.

physician primary care clinic located in Maplewood, Minnesota, just 10 minutes from downtown St. Paul. At Ramsey Clinic-Maplewood, you can enjoy the practice style of a smaller practice, yet benefit from the professional and administrative support of our large multispecialty group. Opportunities to practice obstetrics or engage in teaching and research are optional. Send CV or contact: Karen Steiner, M.D., or Nancy Swenson, Manager, c/o Ramsey Clinic-Maplewood, 1774 Cope Avenue, Maplewood, MN 55109; 612/770-1497. 4-8/95

Multi-Disciplined Rehab Facility in Metro Area, which specializes in the treatment of auto and work-related injuries, seeks physician with similar interests. Great opportunity to join an aggressive team in a unique practice. Contact Craig Seifert, 612/798-1020. 2-6/95

Lecture Series for Single Professionals Ages 35 to 50: We are planning a series of "mini-lectures" on serious and not-so-serious topics. Each session will include hors-d'oeuvres and an opportunity to meet single women and men in a comfortable setting. For more information, call 612/897-6815. *1-5/95

University of Minnesota School of Dentistry invites applicants through 6/30/95 for part-time, non-regular faculty for consultative diagnostic and treatment planning services in specialty clinics. M.D. required, with training and experience in otolaryngology or reconstructive surgery cleft palate patient care. Faculty rank dependent upon experience and training. Send résumé (indicating specialty or area[s] of clinical expertise) to Dean Richard P. Elzay, University of Minnesota School of Dentistry, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. *1-5/95

Internist or Family Physician: Board-certified internist or family physician with expertise in women's health wanted for staff positions for expanding Women's Health Center in St. Paul, Minnesota. The clinic's focus is primary care for women from adolescence through geriatrics. The Women's Health Center is associated with Ramsey Clinic and the St. Paul-Ramsey Medical Center, which are associated with the University of Minnesota Internal Medicine Residency program. Opportunities exist for full- or part-time positions. Please send CV and correspondence to Beth Averbeck, M.D., Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. EOE. *2-6/95

Internist: Board-certified internist with expertise in women's health care and administrative experience wanted to direct expanding Women's Health Center in St. Paul, Minnesota. The clinic is associated with Ramsey Clinic and the St. Paul-Ramsey Medical Center, which are associated with the University of Minnesota Internal Medicine Residency program. Candidates should also have experience in patient care, research, and education. Please send CV and correspondence to Beth Averbeck, M.D., Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. EOE. *2-6/95

WISCONSIN

MINNESOTA

MICHIGAN

ILLINOIS

IOWA

NEW YORK

Great Lakes Great Life

Strelcheck and Associates, a respected search firm, invites you to consider a wide variety of group practice opportunities in the *Great Lakes Region*. Whether you prefer a metropolitan/suburban city, scenic college town, restful resort community, or something in-between, we have the setting for you! Many prominent groups and hospitals have come to rely on our professional approach to physician staffing. Call us toll-free at 800-243-4353 so we can earn your trust as well.



Strelcheck and Associates, Inc.
10624 N. Port Washington Road
Mequon, WI 53092

FAMILY PRACTICE

INTERNAL MEDICINE

PEDIATRICS

HEM/ONC

NEPHROLOGY

OUR HIGH GROWTH LOCALE Means Expanding Opportunity

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404

612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

LaCrosse, Wisconsin

- Live in beautiful Mississippi River Valley.
- Work with high-quality colleagues in growing multispecialty group (70 physicians).
- Competitive income/benefits.

Specialists Needed

Cardiology
Critical Care/Pulmonary Medicine
Dermatology
Emergency Medicine
Family Practice
Internal Medicine
Neurology
Occupational Medicine
Orthopedic Surgery
Pediatrics
Urgent Care
Urology

Send CV to:
P. Stephen Shultz, M.D.
SKEMP CLINIC
800 West Avenue South
LaCrosse, WI 54601
Fax 608-791-9898 or
Phone 608-791-9844 Ext. 6329

MAY 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Army Reserve	48
Aspen Medical Group	51
C.F. Anderson Co., Inc.	32
Central Minnesota Group Health Plan	20
Chisago Health Services	31
CNA Insurance	45
Columbia Park Medical Group	58
Community Care Organization	61
Comprehensive Medical Care	63
East Range Clinics	61
Emergency Practice Associates	32
Fairview Clinic Services	44
Fargo Clinic MeritCare	48
Gillette Children's Hospital	31
Hacienda Publishing, Inc.	15
HealthEast	Cover 4
HealthPartners	41, 58
Health Risk Management	47
LPL Financial Services	27
Mankato State University	57
Memorial Blood Centers of Minnesota	Cover 2
Minnesota Medical Business Resources	Cover 3, 21
Minnesota Physicians Insurance Agency	22, 42, 46, 55
Moonlight Home Health Care	64
Multicare Associates of the Twin Cities	55
Navy Reserve Recruitment Command	61
North Memorial Medical Center	20
Norwest Center	51
Novo Nordisk	3
Oxboro Clinics	62
Park Nicollet Medical Center	62
Ramsey Clinic	31
River Valley Medical Center	32
Skemp Clinic	60, 64
Sletto & Associates, P.A.	27
St. Francis, Inc.	62
St. Joseph's Medical Center	53, 58
St. Paul-Ramsey CME	41
Strelcheck & Associates, Inc.	63
U.S. Air Force Health Professionals	53
Veterans Administration Medical Center	60
Whitesell Medical Locums, Ltd.	44



Introducing, the only auto leasing and purchasing company solely dedicated to serving the health care market.

One year ago, Minnesota Medical Business Resources, a business corporation owned by the Minnesota Medical Association and Hennepin County Medical Society, made the commitment to health care professionals to deliver, and be the premier provider of, products and services that are of high quality and value. As part of our ongoing fulfillment of that pledge, we are pleased to announce the newest member of the Minnesota Medical Business Resources family, MMBR Motor Services.

MMBR MOTOR SERVICES

A MMBR Company

Owned by the members of

MA and HCMS.

Here's what MMBR Motor Services is committed to doing for you:

When you call us, we go to work providing free consultation to help you outline your needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and all models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle.

Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease, or following the purchase of a new vehicle, we will arrange to have your vehicle professionally detailed, assuring high resale value by keeping your

vehicle in like-new condition.

We provide complete support after the lease/purchase. If you have a question, call us.



Remember, this service comes to you from MMBR, your association owned business corporation, so you can be confident in the knowledge that we have worked on your behalf to select the best company to be our partner. For personal attention on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 1/800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center



**OVER
10,000
PEOPLE
ALREADY
KNOW
OUR
SECRET.**

They know it first hand. They know the whole story, from the morning Larry Jones walked again to that day when Mary Butler's pain finally stopped. They know that Minnesota's premier rehabilitation center is just two blocks from the state capitol.

Most folks from the Twin Cities area have heard of HealthEast Bethesda Lutheran Hospital and Rehabilitation Center. It's been part of the community for over 112 years. But when Peter Ridley learned to talk again—and how to breathe without the aid of a ventilator—he wanted to tell everyone that this dedicated facility is one of the best kept secrets in town.

Scope of services: Geriatric Behavioral Care • General Medical Services • Wound Care
Ventilator/Respiratory Care • Neurobehavioral Services • Rehabilitation Inpatient Services
Pain Management • Swallowing Disorder Treatment • Transitional Short-Term Care

For more information
Call 1-800-566-2720
HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center
559 Capitol Boulevard St. Paul, MN 55103

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

Surviving Adolescence

MAURICE AND LAURA FALK LIBRARY
OF THE HEALTH SCIENCES
UNIVERSITY OF PITTSBURGH

JUN 15 1995

12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession, PA 15261-0001

Also Inside:

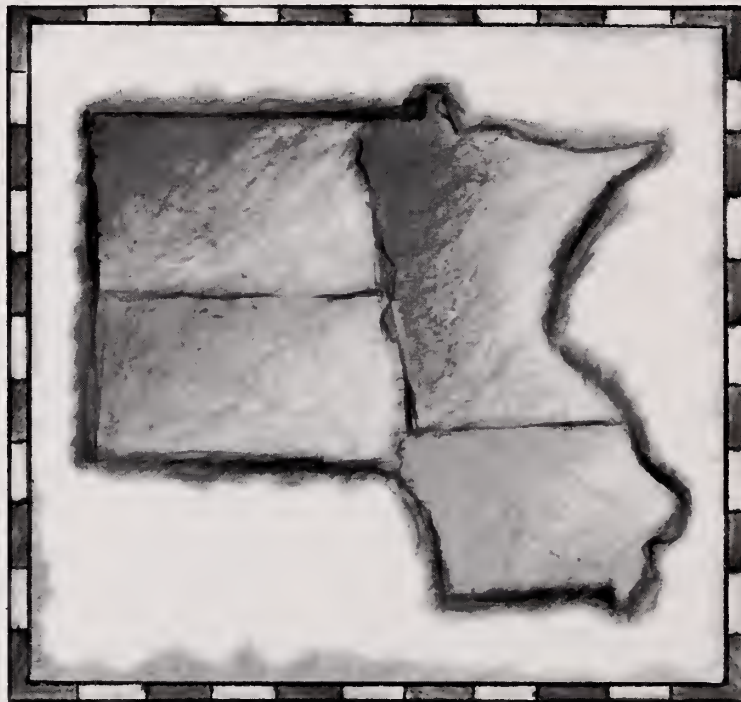
MMA: Stop the Media Violence!

Inside *The Monitor*.

Health Reform '95: A Legislative Summary

JUNE 1995

MIDWEST MEDICAL INSURANCE COMPANY



PROTECTING PHYSICIANS IN THE UPPER MIDWEST

The Midwest Medical Insurance Company was created by and for the benefit of its physician policyholders in Minnesota, Iowa, North Dakota and South Dakota.

MMIC meets the professional liability insurance needs of over 5,000 upper midwest physicians. Its strength and stability are well evidenced by an A (EXCELLENT) rating from A.M. Best.

With assets exceeding \$200 million and surplus of \$65 million to assure that policyholder liabilities will be met, MMIC is able to focus on providing efficient service and attractive premiums.

Physician direction and medical input support the efforts of the professional staff. The service provided by MMIC claims, risk management and underwriting personnel is unparalleled. Coverage enhancements have come steadily since MMIC began in 1980.

MMIC has experience serving large and small medical practices and can provide you with well-designed coverage proposals with competitive rates.

For a quotation or other information about MMIC, please call us at 612-922-5445 or 1-800-328-5532.



MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S., Suite 245, Minneapolis, MN 55435-1891

JUN 15 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Hand-colored photograph by
Deirdre M. Monk with the
cooperation of the Minnesota
Center for Arts Education.

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 28 AUTHOR INSTRUCTIONS
- 45 IN MEMORIAM
- 51 NEWS CLIPS
- 57 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

- 6 THE DOCTOR IS 'IN' WHEN IT COMES TO ADOLESCENTS ...** Miriam K. Feldman
Youth find an open door when they come to Gary Remafedi with questions about homosexuality, AIDS, and other concerns.

FEATURE STORY

- 8 KIDS SHOOTING KIDS: A SURGEON'S RESPONSE.....** Douglas Clement
St. Paul-Ramsey trauma surgeon Michael McGonigal confronts youth violence on his own turf.

EDITORIAL

- 14 TV VIOLENCE** David Walsh, Ph.D.
The great electronic teacher shows kids again and again that violence is fun and entertaining; the real-life consequences are not.

GUIDELINES — MEDIA VIOLENCE

- 16 STOP THE MEDIA VIOLENCE** Mark S. Vukelich
As part of a broader effort to curb violence in our society, the MMA has developed parental guidelines on stopping the media violence.

PERSPECTIVES

- 20 BABIES ON THE VERGE OF HAVING BABIES** David Wallinga, M.D.
From an inner-city clinic, a doctor sings the no-father blues.

PUBLIC HEALTH REPORTS

- 24 HEALTH STATUS OF SUBURBAN HENNEPIN COUNTY ADOLESCENTS** Gayle Geber, M.P.H.
Suburban youth, regardless of their socioeconomic status, often place themselves at risk for serious health problems.
- 29 GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES: ADDRESSING YOUTHS' RISKY BEHAVIORS** Robert W. Blum, M.D., M.P.H., Ph.D., and Trish Beuhring, Ph.D.
The AMA's GAPS address not only the biomedical dangers of youth, but the social, emotional, and behavioral risks as well.

BOOK REVIEW

- 42 A QUIET CRISIS** Patsy Stinchfield, R.N., M.S., C.P.N.P.
"America's Children: Triumph or Tragedy" calls for an overhaul of a fragmented system that jeopardizes our nation's children.

33 *The Monitor*

HIGHLIGHTS .. Review of the legislative session • MMA victory in Vulnerable Adults Act • Viewpoint: Could one wrong decision send you to jail?

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical
Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritzsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

WEBB FINANCIAL GROUP

INVESTMENT ADVISORS



LeAnn Lenander, CFP Les Webb Jerry Webb, CFP

Webb Financial Group has over 44 years in combined investment experience.

We are recognized as a leader in **managing** low to moderate risk
NO-LOAD FUND portfolios for individuals and retirement plans.

We primarily work with portfolios of \$200,000 or more.

Our mission is to help our clients achieve their investment and income objectives,
while maintaining a long term safe haven for their assets.

Call a personal investment advisor at
Webb Financial Group for a no-cost, no-obligation consultation.

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Donald Weinshenker, M.D.
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.



Family Practice

Minnesota, Pine River:

Lakes, pines and quality lifestyle.

Join 1 full time and 2 part-time FPs in beautiful rural area – call share with group of FPs in larger multispecialty clinic in Brainerd. Primary outpatient practice with good support. Affiliation with Brainerd Medical Center (30+ physician multispecialty group) and St. Joseph's Medical Center (162 bed rural referral center/secondary hospital with 60 active physicians).

Send CV or call:

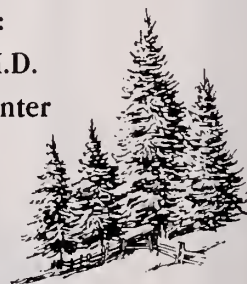
Nicholas Bernier, M.D.

St. Joseph's Medical Center

523 North 3rd Street

Brainerd, MN 56401

(218) 828-7657



Group Health, Inc. Associate Medical Director Quality and Utilization Management

Group Health, Inc. is the staff division within HealthPartners. As one of the largest health care organizations in Minnesota, HealthPartners provides health care coverage and services to more than 630,000 members. Group Health has 2,000 physicians on staff and serves 250,000 members.

We are currently seeking an Associate Medical Director, Quality and Utilization Management to support the Medical Director of our Staff Division in promoting the principles and guiding the integration of Quality Improvement throughout the health care delivery system.

The Associate Medical Director will provide leadership for quality and utilization activities; participate in quality utilization and consulting activities; support integration efforts of QUM programs throughout all of HealthPartners.

Job requirements include Board Certification, five years full-time experience in clinical practice and a formal education in management and proven managerial track record; management experience with a plan for formal education can substitute for formal education. Also required, is knowledge and experience in QUM and managed care principles and excellent communication skills.

We offer a competitive salary and comprehensive benefits package. For consideration or more information, please call Ann Mliner at (612) 883-5337, 800-472-4695 or send CV to: HealthPartners, 8100 34th Ave. South, P.O. Box 1270, Minneapolis, MN 55440-1309. Fax (612) 883-5395.



The HealthPartners family of health plans and health-related companies include Group Health, MedCenters and Ramsey. EO/AA Employer.



HealthPartners

Easing the Growing Pains

Charles R. Meyer, M.D.

"You will make all kinds of mistakes, but as long as you are generous and true, and also fierce, you cannot hurt the world or even seriously distress her. She was made to be wooed and won by youth."

—Winston Churchill

"What old people tell you you cannot do, you try and find you can. ... I am convinced that to maintain ourself on this earth is not a hardship, but a pastime if we may live simply and wisely."

—Henry David Thoreau



"Adolescence seems like a hazardous game played on a shifting court with Alice-in-Wonderland rules."

Growing up has never been a gimme. Childhood, and particularly adolescence, seems like a hazardous game played on a shifting court with Alice-in-Wonderland rules. The temptations of sex, drugs, and crime have always existed, but yesterday's activities seem like child's play compared with today's enticements. Youths' struggles are personal, societal, and medical. This month, we explore the medical implications of the hazards that confront today's kids, and we look for ways to make the passage to adulthood safer.

At first glance, this issue of *Minnesota Medicine* might seem a downer. Kids and AIDS. Kids and violence. Kids and pregnancy. David Walsh shows us how the media fuels an already dangerous society with mesmerizing, money-making violence. David Wallinga elicits pathos in his stories of girls facing motherhood too early. Gayle Geber demonstrates that risky behavior isn't only a problem of somebody else's kids in another part of town. Patsy Stinchfield's review of "America's Children: Triumph or Tragedy" re-

veals the failings of society's safety net for children. Depressing.

Yet this issue also points to solutions. The MMA's Stop the Media Violence Guidelines offer parents tips on how to limit their kids' exposure to violent entertainment. "America's Children," by local authors, has 20 specific recommendations for patching kids' safety net. The Public Health Report by Robert Blum and Trish Beuhring outlines a "How to" for preserving adolescent health. The feature story about Michael McGonigal and our profile of Gary Remafedi testify to the power of good people with good ideas doing good work to fight a bad world. Uplifting.

I suggest the following mandate for physicians treating today's children and their problems:

1. Broaden the scope of what you think medicine should handle. Violence is a medical problem. Violence in the media is a medical problem. Drugs and teen pregnancy should be medical problems *before* they present

as overdoses or deliveries.

2. Speak the truth clearly to your patients and society. Risky behaviors should be labeled with the clarity and succinctness of "Mr. Yuk" stickers. Deceptive reasoning such as that voiced by a media seeking to justify violence as a First Amendment issue should be called the lie that it is.

3. Believe in the power of collective and individual action. Start a program, write a letter, or just take a minute to talk to patients, parents, or passers-by about the problems facing our kids and the existence of solutions.

4. Hug your own kids. My oldest heads off for college this fall, so I am ripe for reflection. There have been lots of hugs but never enough.

During a quote quest for this column, I found that children and youth had almost as many entries as love and money. After all, childhood has been survived by all who reach adulthood. As one wag quipped, "Adolescence is like a hitch in the Army—you'd hate to have missed it, and yet you'd hate to repeat it." Sages have found it fertile ground; few other times of life offer such a treacherous line between triumph and tragedy. A successful kid is a poem; a failed (or dead) kid is a dirge.

Childhood is all potential. Thoreau tells kids they can do anything if they try wisely. Churchill offers them the world if they are generous, true, and fierce (earnest, in Churchill's lexicon). We who built the society our kids will grow up in owe them more than a mere hand-off. We must nurture the skills they need to live generously and wisely. We must keep working on a more sensible world with fair rules and humane values so that they can bring grace and good to life's game. **MM**

... when it
comes to
adolescents...

The Doctor Is 'In'

Youth find an open door when they come to Gary Remafedi with questions about homosexuality, AIDS, and, for that matter, any concern; he's a man with a mission to help young people with their growing array of psychosocial and health needs.

.....
BY MIRIAM K. FELDMAN

"Last night I saw a mirage," says Gary Remafedi, M.D., M.P.H., as he flips through his appointment book to check his day's activities. "I thought I looked at the calendar and saw a blank day when I could catch up on my work."

A blank day would be a blessing for Gary Remafedi, executive director and founder of the Youth and AIDS Projects at the University of Minnesota, where he's also assistant professor of pediatrics. He says of himself, "I have no other life," then soft-pedals that bit of hyperbole: "I do have some other life. But not a lot. It's basically like having two full-time jobs."

The 40-year-old pediatrician admits he is intense when it comes to his work with youth and AIDS, youth and homosexuality, youth and their host of serious needs—all part of a newly recognized field of health care called adolescent medicine. A typical day for Remafedi would include a case conference to discuss the clinic's patients (at any given time there are about 40), a meeting at the university with his department chair, and a meeting at the Health Department to discuss case management services for adolescents with AIDS. Then there would be a hospital visit to a friend dying of AIDS, and later, dinner with a colleague from the Health Department to discuss prevention services for adolescents in Minnesota. Then, and only then, says Remafedi, would he "go home and collapse."

Maybe. Someone like Remafedi can't count on relaxing just because he's home. The other night, for example, he was roused around midnight by a phone call from a 17-year-old Chicago boy, who was calling to say he is gay and needed to talk. The doctor reminded the young caller of the time and kindly suggested it would be better to call at the office—during the day. But he wasn't surprised by the call for help from a boy he'd never met. Remafedi is well aware of his reputation both locally and nationally as the AIDS doctor for young people, as the doctor who advocates for the very special needs of adolescent homosexuals, indeed, as the doctor who brought the subject of adolescent homosexuality and adolescent AIDS to the attention of the medical community.

Remafedi's reputation has earned him spots on lecture podiums, in workshops, and on boards, both locally and nationally. He advises numerous state and local health organizations on youth and AIDS issues, and he consults with President Clinton's AIDS commission on adolescents with HIV. But he always finds time for calls from young people.

"I'd be a hypocrite if I answered the president's call and not the calls from young people," he says. "Who are we here to serve? My client is the adolescent, not the adult."

From a very early age, Remafedi knew who his client would be. "Ever since I was a young child, I wanted to be a pediatrician," he says, citing the influence of his own, empathic pediatrician. After receiving an undergraduate degree from Yale, Remafedi studied medicine at the



"I was interested in serving people who were needy, and it seemed to me that the neediest of children were young people, the adolescents."

—GARY REMAFEDI, M.D., M.P.H.

And he continued to be pulled in that direction. "I was interested in serving people who were needy, and it seemed to me that the neediest of children were young people, the adolescents," Remafedi says. So after medical school, in 1983, he came to the University of Minnesota to study with Robert Blum, M.D., who had established a fellowship program in adolescent medicine. In Minnesota, Remafedi decided to research adolescent homosexuality, a subject absent from his training as well as the literature.

Remafedi's research shattered the conventional thinking that gay and lesbian adolescents didn't exist, or that young people who thought they were homosexual were psychiatrically disturbed.

"What I learned was really startling to me," Remafedi says. He found that homosexual youth were confident of their sexual identities and had been aware of their feelings since early childhood. However, they were at risk for a lot of problems, health-related and otherwise. For example, about 30 percent of the boys he studied had made serious suicide attempts—a rate six times higher than among the general population of adolescent boys.

Remafedi says that today's young people are needier in every way than those of previous generations. Changing family compositions, lack of supervision and support, and an array of problems of a greater magnitude contribute to the growing needs of adolescents. As a result, he says, "Young people aren't as ready as they were in the past to take their places as individuals within society in their early 20s."

Remafedi says the extreme experiences of the young people he sees—the disenfranchised, the home-

University of Illinois, where his intent was to pursue "a conventional career as a general pediatrician." But early on, he was drawn into unconventional situations that shaped the course of his career.

In 1977, four years before AIDS was identified, a fellow medical student asked Remafedi to take part in a community health initiative to address "an awful public health problem going on in the gay community." Gay men were showing unusual manifestations of sexually transmitted diseases (STDs) and unexplained symptoms but weren't being served by the public health department.

Remafedi agreed to join the project, which included a makeshift clinic in an attic above a grocery store. (The clinic subsequently became Howard Brown Memorial Clinic, now a major research and service institute in Chicago.) Remafedi's job was to screen men in bath houses for STDs and to provide treatment on site. "So you know, very early on in my career as a young medical student, I was being drawn into the issue of AIDS and STDs," he says.

REMAFEDI continued on page 46

Kids Shooting Kids

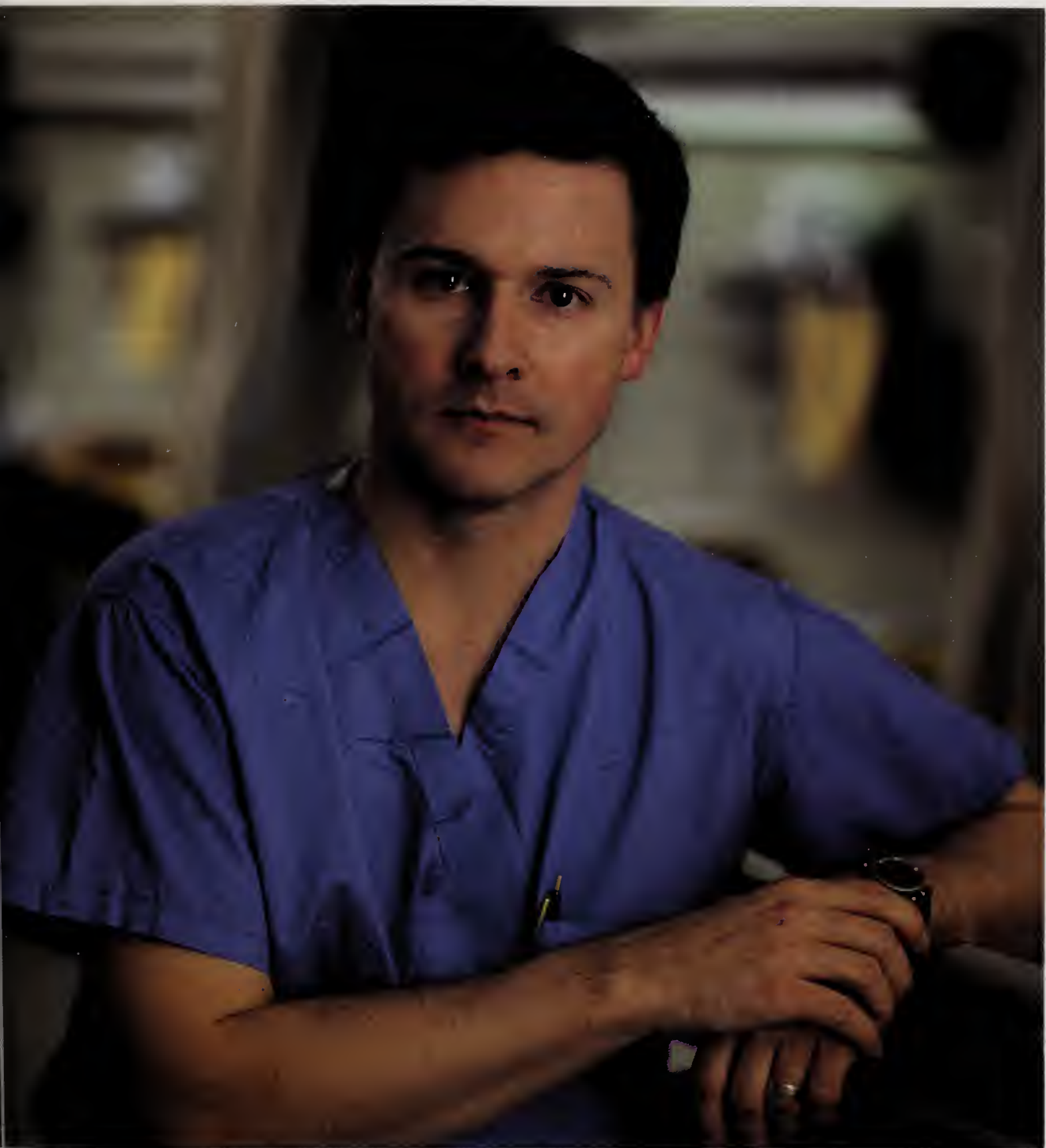
St. Paul-Ramsey trauma surgeon Michael McGonigal confronts youth violence on his own turf.

A Surgeon's Response

It seems fair to assume that death was not on May Lee's mind when she climbed into her friend's car on April 6th and drove to a St. Paul playground for a game of volleyball. But the round-faced girl with the bright smile would never return home. At 7:25 p.m., as Hmong youth gangs began to battle at the playground, a boy pulled out a small handgun and fired it five times. A stray bullet pierced May Lee's skull near the right ear and ripped across both lobes of her brain. On that chilly Thursday evening, at St. Paul-Ramsey Medical Center, the 14-year-old girl was declared dead—an innocent casualty of an undeclared war, a war in which kids kill kids.

Michael McGonigal, M.D., has seen far too many May Lees over the past decade. In Detroit, Philadelphia, and now St. Paul, the 37-year-old surgeon has tried to patch bullet wounds inflicted on children by friends, rivals, siblings, and strangers. The number of shootings was extremely high when he worked in Detroit and Philadelphia, notes

By Douglas Clement



PHOTOGRAPH BY KEVIN WHITE

McGonigal, but in those cities the problem has plateaued. As director of St. Paul-Ramsey's Trauma Service since July 1993, McGonigal observes that here things are growing worse. "What I'm seeing," he says, "is just the beginning of the curve—the beginning of the increase in handgun injuries."

To blunt that curve, McGonigal has launched an innovative program at St. Paul-Ramsey named "Calling

the Shots." The project brings young teenagers into the hospital as participants in a staged drama: for one afternoon, they become trauma staff responsible for saving the life of a gunshot "victim," played by a professional actor, and for explaining to the victim's "family," also actors, that their child did not survive the shooting.

"I wanted to find a way to impress these kids with the

reality of what happens," says McGonigal. "And I wanted to do it in a manner that would make them remember." Drawing on his own experience and working with Mary Kay Boyd, principal of the St. Paul Area Learning Center, and Lou Bellamy, Penumbra Theatre's artistic director, McGonigal designed a "trauma drama" that would bring kids along the same emotional roller

coaster that a trauma team endures. The emotion, McGonigal says, is what anchors the memory for both doctors and teens.

The Violence Curve

McGonigal's program came too late for May Lee. The girl was killed just two days after McGonigal spoke of

St. Paul Teens Feel the Trauma in this Drama

Just when the medical trauma team felt things were going badly for the young gunshot victim, they got worse.

His blood pressure dropped to zero. His pulse went flat. A few desperate moments passed before a nurse pulled a sheet over the man's head.

Outside in the hallway, the homicide victim's mother, father, and sister had arrived, wanting to know what happened. The team members walked out to the emergency room waiting area to break the news.

The four teenagers who made up the "trauma" team had not expected to be thrown in the middle of a dramatization that's played out for real and repeated daily at emergency rooms across the country. They thought all they would do at the hospital that day was watch another video or hear another lecture about gun violence.

What they got instead was a close-up look at the death of a young man, and the disbelief, shock, rage, tears, and sadness of family members, even if they were all roles played by local professional actors.

"I was about to cry," says Beverly Lowe, 16, one of the four streetwise teenagers who participated in the dramatization in December at St. Paul-Ramsey Medical Center.

It was a surprise interactive lesson, a sort of medical "Scared Straight" version of the well-publicized program in which imprisoned killers and other hard-core criminals seek to frighten at-risk youths into becoming law-abiding citizens.

The simulation was thought up and staged at the hospital by trauma surgeon Michael McGonigal. He wants kids who might have guns or who come in contact with firearms to feel what he feels as he tries to save the lives of shooting victims.

So he organized the drama for kids, a production

where the bullet wounds, intravenous hookups, and monitor readings are props, but everything happens so fast that participants are swept away by real emotions.

The eight students who took part in the performances attend Focus on Five alternative school, a program for youths who cut classes or got in trouble at public high schools.

The youths all had espoused the belief that it's better to be armed than to be shot.

"We was thinking, if someone hurt us, we were going to hurt them," says Marcus Page. "After the trauma thing, we wasn't so much into using a gun so quickly."

During the next several months, McGonigal and public school officials plan to put on several more dramatic enactments. The original eight kids have been enlisted as consultants for future stagings. One thing they recommended is an ever-changing script, so no one will know what to expect.

"Guns aren't no joke, man," exclaims Lowe, who says the operating room drama turned her against guns even more than the funeral of her cousin, Romaine Lowe, who died from gunshot wounds three years ago.

"Usually all we see is the arguing part, people shot, and then when they take people away in an ambulance," Lowe says.

Page agrees. "You might be standing there, and you see people get shot and everybody goes down, but that's it. You hear a couple days later if they're dead or alive."

In the hospital drama, Page was assigned the role of "Trauma I," the person who relays the ambulance team's report to his colleagues. Lowe served as the team's leader.

"They came with the ambulance, a real ambu-

Minnesota's rising curve of violence, and hers was just one in a recent string of shootings between Hmong gangs. It's as if "West Side Story" had come to life in Minnesota, but the gangs are called White Tiger and Tiny Man Crew instead of Jets and Sharks. More significantly, the weapons are handguns, not switchblades.

But gun violence is certainly not confined to Hmong

youth nor limited to gangs. National statistics reveal that youth-on-youth gun violence is widespread and growing. Between 1986 and 1992, firearm homicides involving youths under age 18 increased 143 percent. According to the Centers for Disease Control and Prevention, and the Bureau of Justice Statistics, 14 American children are killed by guns every day.

ILLUSTRATION BY MICHAEL MAY



"I want younger kids to know about this. The worst thing that could happen to me right now is to put my brother in a box and bury him. My cousin wants to bless my little brother into his gang."

lance," Lowe recalls. "Here was this dude with 16 gunshots."

"We had to cut off his clothes," says Page. "I had to say, 'Shot to the lower right side near the kidneys'—the kidneys are here, aren't they?"

"We checked his pulse and blood pressure," Lowe interjects.

"Then we had to flick him over," says Page. "The bullet had come out through the left. What we didn't notice was the shot to the back of the head."

"It was already real," says Lowe. "He was moaning in pain. He asked me was he going to die? I started to walk away. I couldn't. I wouldn't want my doctor to walk away. I came back and said, 'We're going to do the best we can.'"

"Then we were about to take him to the operating room, and his blood pressure dropped dramatically," says Page. "He was staring at me. He just stopped breathing. His pulse went 120-90-60-30-flat, and the doc said, 'Forget it.' The thing that got me was when they pulled the sheet over him."

"Then the family," says Lowe. "That made it harder. I went and said, 'I'm sorry, Sir and Ma'am.'"

That's when it was really, really real. The father wouldn't listen to me. The mom got up in my face. They was furious. Then he (Page) said, 'We did the best we could.'"

Lowe went on: "There were real people in the lobby. They didn't know it was an act. But it was no act to me. I was about to cry. Everybody was. My patient died."

The teenagers said they hope the drama will be brought to junior high kids to steer them away from guns and violence.

"I want younger kids to know about this," says Jeff Otis, another student. "The worst thing that could happen to me right now is to put my brother in a box and bury him. My cousin wants to bless my little brother into his gang. He looks up to him because he has all this money."

"If we can't slow this [violence] down," Otis adds, "it's going to go on from generation to generation. It's like a snowball. It gets bigger and bigger."

—By Ann Baker

Reprinted with permission from Baker A. St. Paul teens feel the trauma in this drama. St. Paul Pioneer Press 1995, Jan 8; Sect B:1. © 1995 St. Paul Pioneer Press.

"We see far more shootings than 10 years ago. These are teenagers who use guns to settle differences, use guns as a projection of power, use guns as the way to gain leverage and authority in a society that doesn't respect or value them, or so they perceive."

—TIMOTHY CRIMMINS, M.D.

These national trends are increasingly reflected in Minnesota, especially in the Twin Cities. Arrests of juveniles in Minnesota for serious crimes have risen from 17,116 in 1990 to 20,278 in 1994. Juvenile arrests for *violent* crimes (murder, rape, robbery, and assault) jumped nearly 44 percent in Minneapolis from 1993 to 1994, and 66 percent in St. Paul, according to the Department of Public Safety.

In Minneapolis, the trauma registry at Hennepin County Medical Center shows that the number of patients admitted after a gunshot wound has climbed from 71 in 1982 to 191 in 1993, when nearly 40 percent of the victims were under 20 years of age.

"We see far more shootings than I saw 10 years ago," says Timothy Crimmins, M.D., an emergency physician and chair of the Minnesota Medical Association Board of Trustees. "No question, these are teenagers who use guns to settle differences, use guns as a projection of power, use guns as the way to gain leverage and authority in a society that doesn't respect or value them, or so they perceive. Some of it's drug-related. Some of it's territory and power-related. Some of it is just random."

Part of the problem is simple demographics: more young people are entering adolescence in the 1990s than in the past decade, so unchanged per capita rates of juvenile crime will result in higher absolute numbers. In any case, the numbers represent a daunting level of violence. And as violence has increased, experts have identified poverty, broken families, substance abuse, gang involvement, handgun availability, and the media as contributing factors.

To Counteract Media Violence

McGonigal hopes to curb kid-on-kid gun violence by sensitizing children to the same bloody reality he encounters at the hospital, a reality often obscured by the media. TV shows and movies, observes McGonigal, tend to glorify or sanitize gun violence, and that portrayal numbs kids to the truth.

"There are numerous factors that drive people to resort to gun violence," says McGonigal. "But if you think about it, our exposure to guns and gun violence is primarily from television and the movies. Most kids don't really understand what [guns] can do because what they see is a situation on television where something happens, a gun shows up, it gets used, the victim falls down, and the camera pans away. It's very sanitized, and the viewer never really gets a sense of what really happens."

McGonigal's program *is* what really happens. It starts with careful selection of kids from local schools: kids at risk of becoming involved with guns. McGonigal works closely with teachers and school administrators to identify students most likely to benefit. Informed consent is obtained from students and their parents.

The session begins with a brief orientation for the kids and a group discussion with a clinical psychologist to explore baseline attitudes and experience with gun violence. Next, the kids are familiarized with basic medical techniques of caring for shooting victims. Then they watch a video depicting a party at which an argument begins, a gun appears, a shot is fired, and an ambulance is called to bring an injured teenager to the hospital. Seconds later, a pager beeps, and the kids are told that their "patient" will soon arrive. They rush to the emergency room to begin resuscitation procedures, which, ultimately, are unsuccessful. The medical team must then deliver the bad news to the victim's family. Afterwards, the kids are debriefed by the psychologist, and their attitudes are again recorded.

"The whole program revolves around the simulation, and it has to be very real [to] invoke the same kind of emotional response that [we go through]," says McGonigal. Apparently, the realism pays off. Students in the first run-through in December 1994 were deeply affected by it and have since become active at their schools in spreading the message. "I was very surprised that in a group of kids I thought might be hard to reach, it really hit them hard," says McGonigal.

The program involves about 12 hospital staff, four actors, an equal number of paramedics, and several teachers who accompany the students. All told, each session takes about four hours and costs under \$2,000. As this article goes to press, the program will have just completed its second enactment, with five more scheduled over the next year—all, McGonigal hopes, funded by a Ramsey County grant.

Follow-up surveys of both participants and control

groups will measure the long-term attitudinal and behavioral impact of the program, and McGonigal also plans to package it for use by other hospitals.

Motivated to Make a Difference

The Gun Violence Youth Intervention Project is just one effort, and McGonigal is the first to admit that it will be ineffective if children aren't taught alternative forms of conflict resolution. But however incomplete or untested, his initiative raises the important question of a physician's responsibility to address the growing epidemic of youth-on-youth gun violence.

"As emergency physicians," observes Crimmins "we are what I would call an early-warning system. The first responsibility is to get the word out to other people, to say we are seeing a lot more of this particular type of problem. The next step is far more difficult, devoting our energy and resources to studying the problem and trying to develop a comprehensive public health solution."

A. Stuart Hanson, M.D., has approached the problem from a broad public health perspective as the MMA's representative to the Minnesota Violence Prevention Advisory Task Force. He argues that physicians "have as much or more opportunity" than any other sector in society to identify potential victims and perpetrators of violence.

Physicians can also take a leadership role in persuading schools and communities to teach conflict resolution, says Hanson, a pulmonologist at Park Nicollet Clinic HealthSystem Minnesota. "Let's go to the educators and start talking to them about what our community needs," he says. "It's a long-term thing, and I think physicians ought to be into this for decades."

With substantial support from colleagues at St. Paul-Ramsey, Michael McGonigal appears committed for the long haul. But when one considers his many administrative and clinical responsibilities, his motivation to run this project is somewhat of an enigma. Many—perhaps most—surgeons maintain a tight focus on their practices, avoiding broader involvements. Why would McGonigal devote such energy to an effort so far afield with an outcome so uncertain?

McGonigal's reply to the question has several layers, and he peels them back one by one. As a trauma surgeon, he notes, he has a responsibility to "engage in activities that try to put me out of business." As a trauma center director, he says, he has a responsibility for educating the public. Further, he observes that reducing gun violence will make Minnesota safer for him and his family. But still, he admits, "I don't think that's really the reason."

Then McGonigal recalls how much harder it became

to tell parents that their child had died of gunshot wounds when he himself became a father. "What I always thought when I got into this business was that as I did it for a longer period of time, it would be easier to deal with the tragedy that I see, [and that telling] family members their loved one is dead would get easier," he reflects. "What I discovered, after having a son, was that it gets harder, because now I can put myself in their shoes. It has gotten substantially harder. And I think in some ways, kind of under the surface, that is another one of the things that drives me to do what I'm doing."

Motives, perhaps, are never quite clear, and outcomes may always be uncertain. But McGonigal believes that modest efforts like his are worthwhile because the consequence of inaction is too tragic. "I recognize that the impact I'm going to have is extremely small," he says, "but over time and given other people who have their own small positive effectiveness, things will get better."

MM

Douglas Clement is a free-lance writer and consultant in Minneapolis.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



**Central Minnesota
Group Health Plan**

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

TV violence

The great electronic teacher shows kids again and again that violence is fun and entertaining; the real-life consequences are not.

BY DAVID WALSH, PH.D.

Haunting stories confront us every day as we read the newspaper. The escalating epidemic of violence among youth seems to be taking on increasingly grisly forms. Whether it is the latest story of a senseless assault or murder or a list of statistics like the following, the alarms keep going off:

- gun violence takes a child's life in the United States every three hours;
- more than 5 percent of American school children carry a gun;
- 3.6 million high school students are physically assaulted annually, most by other students;
- violent crime among 15-year-old American boys increased by 264 percent between 1989 and 1993.

Violence, especially among youth, has clearly become a major public health problem. Consider the following: the average cost of treating gunshot injuries now exceeds \$22,000; many assaults leave victims permanently impaired; and the psychological fear and trauma are paralyzing individuals and communities. The medical community must mobilize its efforts to confront this epidemic.

THE CAUSES OF VIOLENCE in America are many and complex: domestic abuse, poverty, racism, drug and alcohol abuse, and others. One factor that is increasingly acknowledged is the viewing of violent entertainment. It would be naive and simplistic to state that the sole cause of violent behavior is violent entertainment; however, it would be equally naive to dismiss its role as unimportant.

"All television is educational. The question is, what does it teach?" This quote by Nicholas Johnson, former chief of the Federal Communications Commission, points out the enormous influence television has on our contemporary society. Unfortunately, this great electronic teacher has been largely enlisted in the service of maxi-

mizing profits for the company owners who control the medium. Television communicates important value messages, especially to children. But the messages are influenced by the main goal of television—profit.

Television is a business. Broadcast TV is paid for by advertisers who have products and services to sell. The more people watch certain programs (in other words, the higher the ratings), the more money the television companies can charge for commercial time. The more money they charge, the higher their profits.

BECAUSE THE NAME OF THE GAME is profit, television networks and production companies will do whatever they can to increase their share of the viewing market. The great "electronic teacher," therefore, has become a huge marketing tool. In order to increase their markets, programmers must capture and hold the viewer's attention long enough for advertisers to sell their messages.

If a program is going to grab and keep your attention, it must arouse you emotionally. Consequently, television producers try to stimulate powerful emotions, and certain things work more reliably than others. At the top of the list is violence, which seldom fails to get our attention and actually causes a physiologic reaction.

It's not surprising, therefore, that a major theme of commercial television is violence, not information or education. Commercial television sticks with violence because it sells. On the way to the bank, however, we are inadvertently teaching our children that violence is fun and entertaining. It is tragically ironic that as we wring our collective hands over the escalating violence threatening us, we continue to teach violence to our children and entertain them with it.

The medical profession has taken the lead over the years in bringing this issue to the nation's attention. The American Medical Association House of Delegates

passed this resolution: "The House declares TV violence threatens the health and welfare of young Americans, commits itself to remedial actions with interested parties, and encourages opposition to TV programs containing violence and to their sponsors." Sadly, that resolution was passed in 1976! Undaunted, violent programming continues its explosive growth.

THERE IS A MYTH AFOOT that no convincing evidence links violent entertainment with violent behavior among youth. This is simply untrue. The evidence is in and is overwhelming. The following organizations have reviewed the literature and concluded there is a demonstrated link between violent entertainment and violent behavior: the American Medical Association, the American Academy

of Pediatricians, the American Psychological Association, the Centers for Disease Control and Prevention, the Surgeon General's Office, and the National Institutes of Health. But, just as tobacco executives continue to deny the link between smoking and cancer, entertainment officials deny the overwhelming evidence linking violent entertainment and violence in our society.

Concern about violence as a theme in entertainment is not based on a matter of taste; it isn't a matter of some people not liking it. The fact is, the diet of violence fed to our children is both killing them and undermining the foundation of our society.

Of course, the concern extends beyond television. Graphic violence in movies and videos has become more and more extreme. Slasher movies such as "Texas Chainsaw Massacre" and "Nightmare On Elm Street" are clear cases in point. Unlike horror films of past generations, these movies portray lots of vio-

TV VIOLENCE
continued on page 48

From the Screen to the Street

Six Ways Film Violence Affects Behavior

The relationship between screen violence and street violence has been studied ever since the early days of television—over 3,000 studies in the past four decades. The majority of findings have established a causal link between the violence on the screen and the violence on the streets. But what is this link exactly? *How* does the violence we watch on the screen affect our behavior? In one such study examining the effects of film violence, social science researchers Daniel Linz, Barbara J. Wilson, and Barbara Randall point to six distinct characteristics of violent content in film and their effect on the viewer.

- **Reward for Violence**—If a violent act is rewarded or left unpunished, it is more likely to foster attitudes supportive of aggression. The lack of punishment actually functions as a sanction or a reward for violent behavior.

- **Reality of Violence**—The more realistically a violent act is portrayed, the more likely it is to be imitated. Older children are more emotionally responsive to programs that depict realistic events and are influenced more by violent movies that feature events that are humanly possible.

- **Violent Role Models**—Children are more likely to imitate and look up to characters whose use of violence is portrayed as necessary or attractive. Moreover, children who strongly identify with a violent media character are more likely to be aggressive themselves.

- **Justified Violence**—The more an act of violence is presented as justified, the more likely it is to be copied. Young children are more apt to hurt than to help a peer after watching a cartoon with scenes of justified violence.

- **Violent Connections**—Viewers who find similarity between themselves and their actions and feelings and a violent act, theme, or character in a film are more likely to imitate or emulate that violence in real life. This is particularly true of children.

- **Amount of Violence**—Excessive exposure to media violence may produce a psychological blunting of normal emotional responses to violent events. It may also lead to a lack of responsiveness to real-life aggression.

Reprinted with permission from the Summer 1993 Media&Values: Media and Violence: Making the Connections. ©1993 Center for Media Literacy, Los Angeles, and summarized with permission from Wilson BJ, Linz D, Randall B. Applying social science research to film ratings: a shift from offensiveness to harmful effects. Part I. Journal of Broadcasting & Electronic Media 1990;34(4).

Stop the Media Violence

As part of a broader effort to curb epidemic violence in our society, the MMA has developed parental guidelines on stopping the media violence.

Mark S. Vukelich

Violence has become a public health epidemic. As a nation, the United States ranks first among all developed countries in the world in homicides. Among the country's youth aged 15 to 24, homicide is the second-leading cause of death, and for African-American youth it is first. In recent polls, Americans listed crime as the No. 1 problem facing our society. Minnesota is no exception. Arrests of juveniles for violent crimes increased by 30 percent in Minneapolis and jumped 46 percent in St. Paul from 1993 to 1994. Rural Minnesota is not immune; juvenile crime is on the rise there as well.

Indisputably, media violence contributes to real-life violence. After 10 years of research, the National Institute of Mental Health concluded: "The consensus among the research community is that violence on television does lead to aggressive behavior by children and teenagers who watch the programs." The conclusion is especially significant because U.S. children are exposed to extremely high levels of TV violence. Approximately five to six violent acts occur per hour on prime-time television and 20 to 25 violent acts are shown each hour on Saturday morning children's TV programs.

Cable TV adds to the problem by introducing new, more violent programs while recycling older violent broadcasts.

A survey conducted by the Center for Media and Public Affairs counted 1,846 violent scenes broadcast and cablecast between 6 a.m. and midnight on a single day. The most violent periods were between 6 a.m. and 9 a.m. and between 2 p.m. and 5 p.m. Experts estimate that by the time young people graduate from high school,

they will have viewed more than 200,000 acts of violence portrayed in various media. Research evidence suggests that children exposed to heavy amounts of violence in the media are much more likely to be aggressive, to exhibit violent behavior, and to view violence as an effective way of resolving conflicts. They may view the world as mean, scary, and threatening and may become desensitized to violence.

Too much time in front of a TV, movie, or video screen can be unhealthy in other ways as well.

- Time spent viewing television or movies or playing video games is time spent *not* exercising.

- Countless food commercials aimed at children promote unhealthy foods and don't



ILLUSTRATION BY STEVE JOHNSON AND LOU FANCHER

give children the full picture about a well-balanced diet.

- Television programs and movies glamorize alcohol use, smoking, and drug use and portray these actions as risk-free. Children must be taught the potential dangers of these behaviors.

- Sexual activity is commonplace on television and in the movies, sending the message that everybody does it, and without consequences. Some researchers link television and movies with increases in teen pregnancies and sexually transmitted diseases.

What Physicians Can Do

The Minnesota Medical Association is working with several organizations to raise public awareness of media violence and its effects on children and adolescents. The MMA's Stop the Media Violence Campaign urges family physicians, pediatricians, and other health care providers to help reduce their young patients' exposure to violence in the media. The MMA has developed guidelines on media violence, posters, and brochures with tips on media violence prevention for parents.

You can help stop the media violence by talking to your young patients and their parents. Discuss violence and the media's role in fostering it as a part of your young patient and parent screening process. Ask parents if they are limiting the amount of time their children are watching television and playing video games. Ask whether they are monitoring the content of the programs their children watch. Most important, educate yourself about the effects of media violence. Be a good role model: don't use television in your office or clinic; instead, display positive posters about reading, sports, and other healthy activities. Finally, share the following guidelines with the parents you see in your office.

Stop the Media Violence: Guidelines for Parents

Set clear limits: Set clear ground rules, such as: no television or video games before school, during daytime hours, during meals, or before homework is done. Limit your children's daily TV viewing and video game playing time to one or two hours—or less. The Center for Media Education estimates that the average preschooler watches three and one-half hours of television a day. Most 8-year-olds watch four hours of television a day.

Don't use the TV as a babysitter: It's very easy to tell your children to "go watch TV" when you are busy (or can't think of anything else for them to do). Using the television, movies, or video games as a babysitter may be convenient, but it can begin a pattern of indiscriminate

viewing and game playing. And, if your children are in a day-care setting, make sure they are not watching television as a substitute for games or other activities.

Don't make the TV the focal point: Avoid placing the television in the most prominent location in your home, and keep TV sets out of your children's rooms. Families watch less television and play fewer video games if the TV is not—literally—at the center of their lives. A television in a child's room encourages more use and diminishes your ability to monitor its use.

Offer other enjoyable activities: Once you turn off the TV, be ready with some other fun activity to take its place. Encourage reading, music-making, hobbies, sports, and social activities as alternatives to television. Help children learn to enjoy active (and interactive) forms of entertainment.

Choose what to watch: Select the TV programs your children watch as you would choose a movie. Decide what to watch and turn off the television afterward to discuss the program with your children. Avoid "channel surfing," and never use television as background noise.

Ban unacceptable programs: Forbid your children from watching TV programs and movies you strongly oppose. Teach children critical viewing skills and be clear about why you avoid certain programs, movies, and video games. Make sure your own actions are consistent with the values you enforce.

Identify high-quality programs: Teach children to be critical of overly commercial, simplistic, violent, and unrealistic programming. Provide examples of what you consider high-quality programming. Watch and discuss some of these programs with your children.

Know what your kids are watching: Watch at least one episode of your children's favorite TV shows. Ask the kids what they like about the programs. Discuss both "good" and "bad" shows, movies, or video games. This activity gives you the chance to discover and correct a child's faulty impressions.

Discuss media violence: Talk with your children about how TV and movie characters solve their problems. Ask your children to come up with more realistic or non-violent solutions. Talk about the violence promoted in the video games your children play. Discuss alternative ways to resolve conflict.

Have a voice in local TV programming: Call or write your local stations and networks to express your approval or disapproval of children's and adult programming, as well as commercial content. Get involved with organizations such as Minnesota's "Turn Off the Violence" coalition (see organizations listed next page).

Committed to Stopping the Violence

Contact these public interest organizations for more information on violence in the media.

Center for Media Literacy
1962 South Shenandoah
Los Angeles, CA 90034
310/559-2944

Center for Reducing Rural Violence
Citizens Council
504 NW First Avenue
Grand Rapids, MN 55744
Donald Streufert, 218/327-9434

Minneapolis Initiative
Against Racism
Media Task Force
4000 Multifoods Tower
33 South Sixth Street
Minneapolis, MN 55402
Gail Rubin, 612/546-0421

Movie Violence Task Force
Minneapolis Foundation
A200 Foshay Tower
821 Marquette Avenue
Minneapolis, MN 55402
Carol Hough, 612/672-3822

National Coalition on
Television Violence
33290 West 13 Mile Road, #498
West Bloomfield, MI 48322
810/489-3177

Public Awareness/
Media Action Group
Community Prevention Coalition
of Hennepin County
525 Portland Avenue South, #810
Minneapolis, MN 55415
Howard Epstein, 612/348-7550

Turn Off the Violence
Citizens Council
PO Box 27558
Minneapolis, MN 55427
612/593-8041

Voice Your Opinion

To voice your approval or disapproval of programming, write to these television networks, media organizations, government agencies, or your congressional representative.

Entertainment Industry

ABC Entertainment
2040 Avenue of the Stars
Los Angeles, CA 90067

CBS Entertainment
7800 Beverly Boulevard
Los Angeles, CA 90036

Fox Broadcasting Company
Network Division
1211 Sixth Avenue
New York, NY 10036

National Association
of Broadcasters
1771 'N' Street NW
Washington, DC 20036

National Cable TV Association
1724 Massachusetts Ave. NW
Washington, DC 20036

NBC Entertainment
3000 West Alameda
Burbank, CA 91523

Public Broadcasting Service
1320 Braddock Place
Alexandria, VA 22314

Turner Broadcasting System
1 CNN Center
Atlanta, GA 30303

Government

Consumer Protection Bureau
Federal Trade Commission
Washington, DC 20580

Federal Communications
Commission
Mass Media Bureau
2025 'M' Street NW, Rm. 8210
Washington, DC 20554

U.S. House of Representatives
Subcommittee on Telecommunications
B-331 Rayburn Building
Washington, DC 20515

U.S. Senate
Subcommittee on Communications
227 Hart Senate Office Building
Washington, DC 20510

Acknowledgments

The Minnesota Medical Association thanks the following organizations for their assistance with the Stop the Violence Campaign: the American Academy of Pediatrics, American Medical Association, Center for Media Education, American Psychological Association, and the National Institute of Mental Health. Special thanks to Minnesota Attorney General Hubert H. (Skip) Humphrey III; David Walsh, Ph.D., Fairview Behavioral Services; Margie Hogan, M.D., Hennepin County Medical Center; Leah Skurdal, Molly Koivumaki, and Sheila Miller, Turn Off the Violence (administered by the Citizens Council); Audrey Anderson, Wilder Foundation; and Robin Hickman and Glorius Martin, KTCA's "Don't Believe the Hype," for their support and promotion of this campaign. The MMA Stop the Violence Campaign is supported in part by a grant from the Allina Foundation.

Mark Vukelich is communications director for the Minnesota Medical Association.

To obtain materials, contact MMA Stop the Violence Campaign, 3433 Broadway Street NE, Minneapolis, MN 55413, or call MMA Communications Director Mark Vukelich at 612/378-1875 or 800/999-1875.

MMA's Stop the Violence Campaign

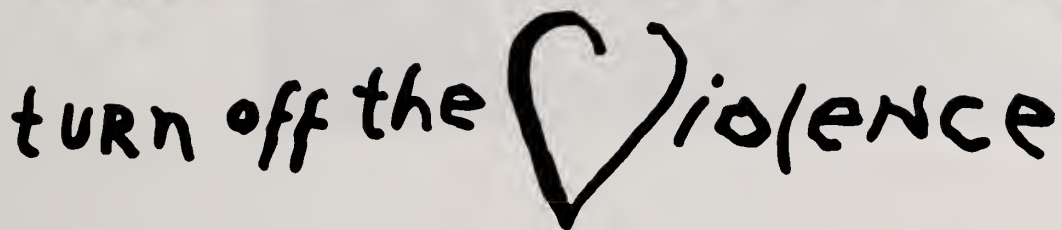
Fall 1992: MMA begins the "Stop the Violence" campaign against domestic violence and abuse by developing diagnostic guidelines for physicians.

Winter/Spring 1993: MMA launches a public relations campaign to curb domestic violence and abuse. Billboards, radio public service announcements, bumper stickers, posters, and buttons are distributed throughout the state. MMA receives Gov. Arne Carlson's Violence-Free Minnesota Award.

Summer 1994: MMA presents first annual "Stop the Violence Awards" to the Duluth Domestic Abuse Intervention Project; to WomanKind founder Susan Hadley, M.P.H.; and to A. Stuart Hanson, M.D. MMA receives the American Society of Association Executives' Summit Award.

Spring 1995: MMA expands the "Stop the Violence" campaign to include media violence. MMA develops guidelines for physicians to share with young patients and their parents to limit children's exposure to violent entertainment.

June 1995: MMA publishes a special issue of *Minnesota Medicine* on adolescents' risky health behaviors—youth-on-youth violence among them. The MMA unveils guidelines on media violence at a news conference and begins a public awareness campaign to stop the media violence.



turn off the Violence

OCTOBER 12, 1995

Violence is a learned behavior. It can be unlearned.

On Turn Off the Violence Day, October 12, we are asking people to turn off violent television, movies, and music and to plan enjoyable, non-violent alternatives. Make plans with family or friends to take a hike, read to children or hold a family olympics . . .

The possibilities are endless!

For too many people, violence is becoming an acceptable way of resolving conflicts. We ask Minnesotans to learn non-violent ways to resolve family and community conflicts.

TURN OFF THE VIOLENCE, P.O. BOX 27558, MINNEAPOLIS, MN (612) 593-8041

Babies

ON THE VERGE OF HAVING

Babies

PHOTOGRAPH FROM SWANSTOCK BY M.L. LINCOLN & SUE COST



From an inner-city clinic, a doctor sings the no-father blues over kids who surely are too young.

by David Wallinga, M.D.

The nurses huddle in a whisper outside the exam room. I look at them, they roll their eyes, and I grab the patient's chart from its slot beside the door. I am one of two doctors at this community clinic on Minneapolis's south side, a cinder-block building that served as a supermarket until the owner was robbed and killed some six years ago. In this neighborhood the unexpected happens. The top of the chart lists the basic facts: Name, Sex, Race, Reason for Visit.

She is 13 years old and needs a "urine test." She sits on the exam table facing forward as I enter the room behind her. The fluorescent lights glisten off blue-black hair that hangs to her shoulders, and her left ear supports two studs and an enormous gold hoop earring. Eyes dark as cave water draw my gaze to her unlined face. They look unblinkingly ahead as I talk, staring at the wall perhaps or at pamphlets that warn about sexually transmitted diseases or at posters that say, "Learn about AIDS." She does not look at me.

"Hi, Donna. My name is David, and I'm one of the doctors here." She looks at my

outstretched hand hanging midair but makes no move. I must seem intolerably foreign. My 6-foot-2-inch frame beside hers; the stethoscope draped around my neck lording my authority over her.

I grab a stool that leaves me peering upwards. "Can you tell me why you came to the clinic today?"

She says easily, "I think I'm pregnant," with no catch in her throat, casual as I might expect her to say she's caught a cold.

"What makes you think that?"

"I don't know."

"Well, when was your last period?"

She purses her lips, irritated, like I'm crazy to think there's any connection between having babies and missing her menses.

"I don't remember."

"More than six weeks, say?"

"Yeah, maybe. Sure, six weeks."

Christ. I force myself to remember she is only an eighth-grader, though she doesn't look it. She looks older—sexy even.

Tall, nearly 5-foot-8, with hip-hugging designer jeans, high-topped tennis shoes, and a madras shirt that tugs against precociously large breasts.

I try a different tack. "Have you had any of the symptoms of pregnancy, things like feeling sick to your stomach in the morning, or your breasts being bigger or more tender?"

"I was feeling a little dizzy—that's why my mama told me to come down here."

"Have you been sexually active? I mean, have you been having intercourse with anyone?"

"You mean sex? Yeah, I've been having sex."

"With your boyfriend? Anyone else?"

"No, just him." She's calm. I cannot believe it, remembering myself at 13 and how new it all was, the words, the images, when even the mention of sex by an adult would have made me hot and my cheeks flushed. She speaks the language of sex with an unconscious ease.

"Donna, are you on the pill or using condoms?"

"No."

"Any birth control at all?"

"No."

"Didn't we tell you last time how important it is to use condoms?" I curse the note of condescension that creeps into my voice, and watch as her

coffee pupils flash angrily, then cloak themselves.

"Without condoms you know you could get AIDS or an infection that will sterilize you? That means you wouldn't ever be able to have kids."

"But I want a baby," she says.

"I want a necklace. I want a Nintendo. I want a Barbie doll," I think to myself.

"How about your boyfriend, does he want to be a father?"

"He's not really my boyfriend. He's just a boy I know."

"Donna, have you thought about how hard it would be to raise a baby and try to finish school? Without school, how are you going to support your baby?"

"My mama will help me. Besides, my cousin's doing it."

"Yes, but babies are a lot of work. Diapers and nighttime feedings and staying home on weekends. Are you ready for that?"

"I don't know, but I want a baby." She looks straight at me for the first time. Her voice is flat and hard-edged, not a quiver in it. I know that look, that voice, the way the corners of her mouth are set firm: everything says having a baby is the one thing in her life that she knows she can do. The one thing in her life she can actually plan for. I feel compelled to *do* something, to tell her that any idiot can have a baby, but that it takes a mature person to raise one. I want to talk about responsibility. How I'm over twice her age and don't feel ready for kids. Most of all, I want to grab her by the shoulders and shake her until she believes it's a damn poor idea.

But I know Donna will have her child. Maybe not this year, maybe not even until she's 15, but she'll have it.

"Your test is negative. You're not pregnant," I tell her, instead. Her eyes soften in disappointment.

On a busy morning at the clinic, four charts fill the slots beside each of four exam rooms. I grab the next one and look at the patient's vital signs: she is 14 years old and needs birth control. I catch my breath and walk in.

A girl sits on the exam table straddling the space between two heavy black, iron stirrups that have been pulled out and await her. A cotton exam gown engulfs her narrow shoulders. She slumps over slightly. Eyes the color of record vinyl, the

size of 45s look straight down at the level of my shoes. Her black hair zigzags every which way, and odd little plastic balls hold short clumps of her hair in place.

"Hi, Angie. What brings you to the clinic today?"

The girl shrugs and retreats further into her gown. Buying time to observe her, I bounce the red rubber head of my reflex hammer on top of the desk and pretend to look through the chart. She stays dead silent, and I notice her hands clenched in her lap and her legs dangling outward, like kinked green willow branches trying to straighten themselves up. She's wound up. "My chart says you're here for birth control. Have you been on any before?"

She shakes her head no, almost imperceptibly.

"Well, there are lots of different kinds that we can talk about, but um ... before anyone gets birth control, we need to do a pelvic exam and Pap smear. That means I'm going to examine your uterus and vagina with my hand and also with a speculum, sort of a small metal funnel."

Her shoulders sink still lower, and her eyes turn glassy, suffused with fear.

"You've never had that kind of exam, have you, Angie?"

A slow, insistent shake of the head.

"I know it sounds scary, but it's really OK, as long as we help you get relaxed." She starts to cry. No words, no sound, a tear snakes down her cheek. I rest my hand on her shoulder and she holds so still my fingers don't even wrinkle the fabric of her blouse. Neither of us says anything for several long seconds.

"Angie, have you ever been sexually active? Are you

having sex with anyone?"

"I don't even have a boyfriend," she blurts out. Her lower lip trembles a bit.

"Did your mom come with you today?"

"She's waiting outside."

"Oh. I bet it was mostly her idea for you to come see me today, wasn't it?"

Her head snaps up. Her eyes plead for understanding. "Yes," she spits. It's an accusation, not an answer.

"You know, Angie, before we do anything else, I think your mom needs to come in and the three of us can talk for a bit about what you'd like to do. Then, if you do get an exam, we can have our female doctor do it. OK?"

I'm sorry for her. Angie lives in a society where her mother, her teachers, even I—everyone who wants her to do the right thing—fully expect her to do the opposite. What choice do we have? Yet, Angie is the one who pays the consequences.

The girl lifts her neck, straightens her shoulders, and lets out a sigh that stretches on. She doesn't have to say anything. Her silence speaks her relief.

"You can get dressed now," I say, and slip out the door. MM

David Wallinga now lives in New York City. He lived in Minneapolis when he wrote this story and practiced medicine at several community clinics here.

Reprinted with permission from Wallinga D. Babies on the Verge of Having Babies. Minnesota's Journal of Law and Politics 1995; April: 43. ©1995 BRJG Publishing.



Join Dr. Hanley.

"I think one of the greatest contributions of the AMA is its activities on behalf of the most vulnerable in our society, children.

"The AMA adolescent health program is a great benefit to physicians who practice adolescent medicine and to policy-makers. But there is so much more that needs to be done. The AMA deals with the seemingly countless number of issues confronting medicine. And because it does, it gives me a great feeling of hope about the future.

"I can't imagine what the state of medicine would be without the AMA."

Join Dr. Kay Hanley, Pediatrician, in the American Medical Association. Call this toll-free number now.

Join The AMA.

1-800-AMA-3211

American Medical Association



COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
 Bloomington, MN 55437
 Local (612) 881-0618
 WATS (800) 328-6246
 FAX (612) 881-7297



C.F.
anderson
 COMPANY, INC.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
 Physician Placement Dept.
 Fairview Clinic Services
 600 West 98th Street, Suite 390
 Bloomington, MN 55420
 1-800-842-6469



THUNDERBIRD AVIATION

FAA 141 APPROVED FLIGHT SCHOOL
GROUND & FLIGHT TRAINING FOR PRIVATE
 • INSTRUMENT • COMMERCIAL • MULTIENGINE
 • ATP • FLIGHT INSTRUCTOR



**OVER 30 YEARS
 EXPERIENCE**
**AREA'S LARGEST FLEET
 OF PIPER AIRCRAFT**

**RENTAL - AIR CHARTER
 AIRCRAFT SALES,
 MAINTENANCE & FUEL SERVICE**

941-1212

LEARN TO FLY

FLYING CLOUD AIRPORT, EDEN PRAIRIE

Health Status of Suburban Hennepin County Adolescents

Suburban youth, regardless of their socioeconomic status, often place themselves at risk for serious health problems. Physicians can help by being approachable and offering information on such topics as sex, AIDS, and alcohol use.

Gayle Geber, M.P.H.

Editor's Note: It is no news to any of us that adolescence is a difficult life stage. However, an article such as this one can remind us just how difficult the problems may be and how frequently they occur even in privileged, suburban, middle-class children. While the statistics can be discouraging, our second Public Health Report in this issue (page 29) discusses the Guidelines for Adolescent Preventive Services, which provide us with tools for early recognition and perhaps even prevention of the physiological, psychological, and social "dis-ease" of teens. GAPS is a program the American Medical Association and all its physician members should view with pride. But the recommendations are of little use without implementation. How do you plan to incorporate them into your practice?

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

The stereotype of suburban adolescents is that they are bright, wealthy, and healthy kids whose futures are wide open. For many suburban youth, reality is much different. Adolescents, regardless of their socioeconomic status, can place themselves at risk for serious health problems, often by virtue of their own behaviors.¹⁻³ All adolescents face challenging issues, such as planning for the future, understanding their new social and family relationships, and coping with stress. Suburban adolescents are no different, nor are the problems they encounter when working through these issues.

The Minnesota Department of Education's Minnesota Student Survey (MSS) allows students to express their own health needs. In 1992, the MSS surveyed students in the sixth, ninth, and 12th grades in public "regular" (not alternative) schools. The Hennepin County subset included 15,421 students: half were girls and 84% were white. Because adolescents not attending "regular" schools were excluded from this sample, results may somewhat understate the problems of all suburban youth.

HEALTH NEEDS ASSESSMENT

POVERTY AND LIVING SITUATIONS
According to census data, 77,170 adolescents aged 12 to 21 lived in suburban Hennepin County in 1990. Just over one in 10 suburban youth aged 12 to 17 belonged to families

with incomes below 200% of poverty (approximately \$2,400 per month for a family of four). Older youth were more likely to live in poverty: two in 10 suburban youth aged 18 to 24 lived below 200% of poverty.

Of the suburban Hennepin County students represented in the MSS, two-thirds lived with their married birth parents, one-fifth lived with a divorced parent, and one-tenth lived in other types of families.

MENTAL HEALTH

Mental health problems are perhaps the most serious health problems for suburban adolescents. Nationally, about 12% to 15% of children and adolescents suffer from emotional or other mental health problems that warrant treatment, but only an estimated 20% to 40% of youth needing services actually receive them.⁴

In the MSS, suburban Hennepin County youth report high levels of stress. When asked if they were under any stress or pressure during the past month, 49% of the 12th-graders reported "almost more than I could take" or "quite a bit," as compared with 35% of the ninth-graders and 20% of the sixth-graders.

Suicide attempt rates by suburban students were similar to the rates of students statewide, with girls reporting more attempts than boys in the ninth and 12th grades (see Figure 1, facing page).

The stresses suburban students experience also were reflected in the context of what they worry about:

65% of students surveyed worry about doing well in school, while only 49% worry about how they look, and 12% worry about whether they're normal. More students of these ages worry about getting a good job (47%) than about having friends (44%).

In most cases, the physical needs of suburban youth are being met, but in many cases their emotional needs are not. It appears that many adolescents have come to believe that being "average" is not acceptable. They believe "average" does not meet their parents' or society's standards, nor does it meet their own internalized standards of success. This places a significant burden on adolescents, who often lack supportive adults who will listen to their concerns and offer a more balanced perspective on achievement.

CHEMICAL USE

Although many students engage in chemical use (see Figure 2), between 1989 and 1992 both recent drug use (any in the past 12 months) and regular drug use (monthly, weekly, or daily) have decreased for ninth- and 12th-graders.

Problem drinking behaviors were evident in the data: 25% of students in the ninth and 12th grades drank to intoxication (four or more drinks on a typical occasion). Twenty-two percent of 12th-graders reported that they drive after drinking or using other drugs.

SEXUALITY, REPRODUCTIVE HEALTH, AND AIDS

Among the suburban Hennepin County students surveyed, the average age at first intercourse was 13.1 years for ninth-graders and 15.5

years for 12th-graders. Twenty-five percent of ninth-graders and 55% of 12th-graders have had sexual intercourse. These figures are slightly lower than for the state population of teens: 30% of ninth-graders and 61% of 12th-graders in Minnesota have had sex. Of the adolescents who have had sex, 52% of the ninth-graders and 40% of the 12th-graders do not always use a contraceptive. The birth rates for suburban adolescents rose between 1980 and 1990 for 15- to 17-year-olds as well as 18- to 19-year-olds, although they are lower than the rates for the state population of adolescents.

Sixteen percent of students in the sixth, ninth, and 12th grades said they worry about getting a sexually transmitted disease (STD). Their concern seems well-founded. Surveil-

lance data from 1992 indicate that the incidence rates of gonorrhea and chlamydia for suburban 15- to 19-year-olds are significantly higher than for other age groups, although the rates are lower than for Hennepin County youth as a whole.

Having multiple sexual partners increases the likelihood of acquiring STDs and AIDS. Of ninth- and 12th-graders who have engaged in sexual intercourse, 45% of boys and 38% of girls have had multiple sexual partners of the opposite sex in the past year; 4.4% of boys and 0.8% of girls have had multiple same-sex partners. Students' most common sources of information about AIDS were television, radio, and schoolteachers or staff.

VIOLENCE, ABUSE, AND NEGLECT

One in 10 of the sixth-, ninth-, and 12th-graders surveyed report that they have been physically abused by someone in their families. Although only one in 10 students worry about violence in their schools or neighborhoods, 47% of sixth-graders, 42% of ninth-graders, and 26% of 12th-graders reported in the MSS that they have gotten in physical fights or beaten someone up in the past year. These rates closely parallel those for the state.

Students also reported date-related violence: 15% of 12th-graders and 9% of ninth-graders said they have been hit by a date in anger. These rates did not vary by gender. Students were also asked if a friend or date had ever forced sex on them. Eight percent of ninth-graders and 10% of 12th-graders said they had experienced this, whereas only 3% of ninth-graders and 2% of 12th-graders admitted to forcing someone into sex with them. Sexual violence during dating, however, does vary markedly by gender, with more boys forcing sex and more girls being forced into sexual activity.

WHAT CAN PHYSICIANS DO?

Primary care physicians have ample opportunity to improve the health of their adolescent patients. Preventive health education begins with an un-

Figure 1
Suicide Attempts

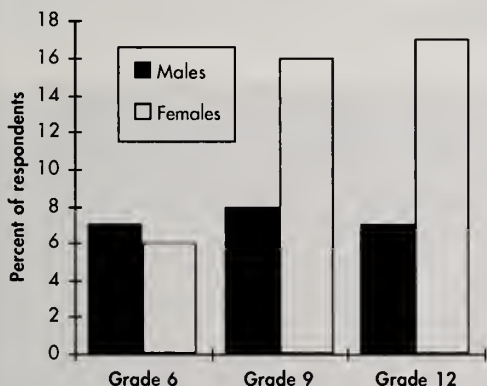
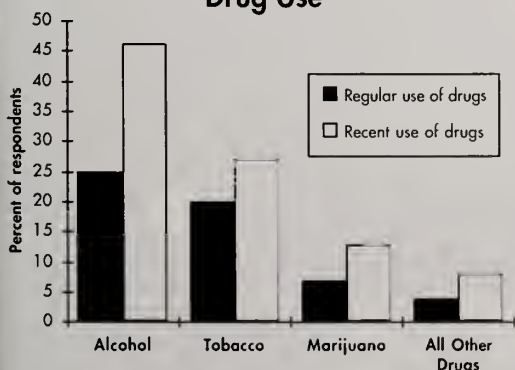


Figure 2
Drug Use



derstanding of social morbidities in all patients, even the more affluent ones. Physicians should be approachable and visible to their adolescent patients, few of whom see physicians as important sources of information on sex, AIDS, or alcohol. Physicians need to be aware of potential mental health problems among adolescents and make appropriate referrals. Concerned physicians can lend their particular expertise to preventive public health efforts by joining community partnerships aimed at preventing these problems. Because parents play a large role in their children's healthy futures yet often lack support and information on adolescence, physicians should increase their communication with parents of preteens and teenagers without breaching the confidentiality of their adolescent patients. **MM**

Gayle Geber is a senior planner at the Hennepin County Community Health Department.

REFERENCES

1. American Medical Association. White paper on adolescent health. Chicago: American Medical Association, 1988.
2. Kann L, Warren W, Collins JL, Ross J, Collins B, Kolbe LJ. Results from the national school-based 1991 Youth Risk Behavior Survey and progress toward achieving related health objectives for the nation. *Pub Health Rep* 1993;108(suppl 1):47-67.
3. Adolescent health: volume I—summary and policy options. Washington, D.C.: U.S. Congress, Office of Technology Assessment, 1991. U.S. Government Printing Office publication OTA-H-468.
4. Children's mental health: problems and services—background paper. Washington, D.C.: U.S. Congress, Office of Technology Assessment, 1986. U.S. Government Printing Office publication OTA-BP-H-33.

Physician Reviewers

Health Risk Management provides comprehensive health care quality management and information services based on our nationally recognized healthcare practice guidelines. The continuing growth of our care management business requires additional part-time consulting physicians to apply clinical expertise to patient care review. You will work within your medical specialty field to provide care review services and serve as an educational resource to our clinical staff.

We are seeking physicians with backgrounds in:

- INTERNAL MEDICINE
- GENERAL SURGERY
- ORTHOPEDICS
- PERINATOLOGY
- NEUROLOGY
- CARDIOLOGY
- FAMILY PRACTICE

To qualify, you must be actively licensed and board certified, have related experience, and knowledge of managed health care.

We offer:

- Competitive pay
- Opportunity to complement your expertise
- Flexible part-time schedules including day, evening and on-call night shifts on weekdays and weekends

Medical professionals interested in helping shape the future of health care should send CV to Human Resources, fax (612) 829-3664 or call 829-3540 for more information: Health Risk Management, 8000 West 78th Street, M.S. 8-210, Minneapolis, MN 55439. EOE.

HRM[®]

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree™

Minneapolis 667-0705

©1995 Norwest Bank Minnesota N.A.
Member FDIC

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 270 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice
- OB/GYN
- Urgent Care
- ENT - Bemidji
- Pediatrics - Bemidji
- Orthopaedics - Detroit Lakes, Bemidji



MeritCare Medical Group
737 Broadway • Fargo, ND 58123

For more information contact:
Kathleen McKittrick Toft,
Director, Physician Recruitment
1-800-437-4010



\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to \$30,000 in the Army Reserve.

- Anesthesiology
- General Surgery
- Thoracic Surgery
- Pediatric Surgery
- Orthopedic Surgery
- Colon-Rectal Surgery
- Vascular Surgery
- Neurosurgery

A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a \$10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors:

CALL COLLECT:
CPT. RICK OTTO
612-854-7702

ARMY RESERVE. BE ALL YOU CAN BE.®

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Guidelines for Adolescent Preventive Services

Addressing Youths' Risky Behaviors

The American Medical Association's GAPS address not only the biomedical dangers of youth, but the social, emotional, and behavioral risks as well.

Robert W. Blum, M.D., M.P.H., Ph.D., and Trish Beuhring, Ph.D.

The major sources of morbidity and mortality during adolescence—accidents, violence, substance abuse, depression, suicide, sexually transmitted diseases, and unintended pregnancies—have predominantly social and behavioral etiologies.¹ To provide clinical guidance related to these issues, the American Medical Association recently issued Guidelines for Adolescent Preventive Services (GAPS), a comprehensive set of recommendations that address not only the biomedical risks of youth, but the social, emotional, and behavioral risks as well.²

Current data on adolescent health show that more youth are engaging in health risk behaviors than in the past, and at younger ages.³ Moreover, many young people who engage in one health risk behavior are likely to engage in others.⁴ GAPS represent the first systematically developed set of recommendations for providing comprehensive adolescent preventive services that address these contemporary health threats. They are designed for primary care practitioners and other health care practitioners who see adolescent patients in clinical settings.

GAPS AND THEIR SIGNIFICANCE

As clinicians have become increasingly aware of the major morbidities during the second decade of life, they have also questioned whether we currently provide appropriate health

promotion counseling and screening for the major morbidities of youth.

GAPS were developed in collaboration with a national scientific advisory board* and reflect a compilation of expert opinion, findings from the current research literature, and recommendations developed by other expert groups. They comprise 24 recommendations designed to be practical, effective, and implemented during a series of annual preventive health service visits for youth aged 11 to 21 (see Table 1, page 30). In general, the recommendations do the following:

- provide a framework for routine adolescent health care that emphasizes annual visits, confidentiality, and appropriateness for age, gender, and culture;
- encourage practitioners to give health guidance to adolescents and their families with a focus on developmental and psychosocial adjustment in order to promote healthy lifestyles and prevent injuries;
- advocate screening for behav-

iors and conditions whose prevalence and severity may pose a threat to an adolescent's health in the short term and/or later in life; and

- advocate immunizations for preventable infectious disease.

GAPS are unique in several respects. The types of primary and secondary health care services they recommend are consistent with changing adolescent health status indicators. The guidelines recognize and depend on the relationship between primary care practitioners, adolescents, and parents. The recommended annual visits provide opportunities for physicians to identify prepathology or the initiation of high-risk behaviors, as well as early stages of physical and emotional conditions that require treatment. Thus, GAPS have the potential to significantly reduce morbidity and mortality among adolescents at an early stage, while saving health care dollars.²

Thirteen of the 24 guidelines focus on screening (see Table 2, page 31). The screening guidelines can be grouped into five categories: biomedical, physical health, psychosocial health, substance use, and sexual behavior. Together, these five domains represent 21 interrelated issues.

HISTORY AND PURPOSE

The Institute of Medicine describes practice guidelines as "a systematically developed set of statements [designed] to assist health profes-

*Author Robert Blum was a member of the scientific advisory board, which included representatives from the American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Psychiatric Association, and Society for Adolescent Medicine.

sionals with patient decisions about appropriate health care for special clinical circumstances."² Although the concept of "guidelines" is less compelling than protocols or criteria, they are intended to convey a goal toward which services should strive.

GAPS were built upon the work of the U.S. Preventive Services Task Force, with a focus on adolescents. The goal was (and is) to establish a set of guidelines that is as well accepted for adolescents as is the well-child schedule for patients from birth to five years of age. If successful, the Institute of Medicine notes, thoughtful, scientifically based guidelines reduce individual practitioner variability, improve outcomes from the clinical encounter, reduce long-

term costs of health care, and expand provider awareness of critical issues.

To accomplish these goals, the scientific advisory board reviewed and debated all extant literature on the target issues, discussed clinical approaches, and articulated differences of opinion. Where data provided clear guidance there was little debate; where the data were more ambiguous, as is often the case in clinical practice, the guidelines reflect the more provisional nature of the scientific advisory board's thinking.

In addition to being an academic process of identifying an optimal set of guidelines that advance adolescent health promotion, establishment

of GAPS is a distinctly political process. Consequently, representatives from seven different professional organizations were part of the planning and participated on the scientific advisory board (see footnote, page 29).

REFINING GAPS

Because neither academic review nor academy approval assures utility of the guidelines in the primary care setting, focus groups of practitioners have analyzed GAPS' applicability to the private practice setting, and practitioner offices are currently conducting pilot tests of the guidelines.

The AMA's Guidelines for Adolescent Preventive Screening provide a carefully researched, comprehensive first step toward implementing age-appropriate health screening for adolescents. However, a study we conducted to analyze the adolescent health promotion and screening behaviors of clinicians in the Twin Cities (manuscript under review) suggested that some of the guidelines should be revised. Although we cannot summarize data from the study, we can suggest the following revisions:

1) adding to and perhaps deleting from the list of screening issues;

2) incorporating into the guidelines a list of strategies for dealing with sociobehavioral health risks; and

3) including information on the generality of screening needs across socioeconomic and rural-urban lines.

These and other issues are likely to be addressed in the course of the field testing that is currently underway with GAPS.

CONCLUSION

It is not sufficient to merely develop guidelines. A strategy for implementing GAPS in the clinical setting is necessary if we are to use the guidelines and significantly improve preventive adolescent health care in the United States. The AMA has already operationalized GAPS with an Adolescent Health History form to allow for easier access by clinicians to the key GAPS variables. The time invested now in implementing and evaluating screening will result in earlier detection, and thus earlier and less expensive intervention, of

Table 1

The GAPS recommendations: general, health guidance, and immunizations

Area	Recommendation
General	1. An annual visit is recommended for all young people from 11 to 21 years of age. 2. Preventive services should be sensitive to developmental and sociocultural variations. 3. Clear policies on confidentiality need to be established and communicated to parents and adolescent patients.
Health guidance	4. At a minimum, health guidance should be provided to the teenager and primary caregiver during early and middle adolescence and ideally during late adolescence as well. 5. Annual health guidance should promote understanding of physical, psychosocial, and psychosexual development, as well as the importance of being an active health care decision maker. 6. Annual health guidance should promote injury reduction. 7. Annual health guidance should describe safe weight management, dietary habits, benefits of and methods to achieve a healthy diet. 8. Annual health guidance should include benefits of and strategies for regular exercise. 9. Annual health guidance should promote responsible sexual behavior, including abstinence, and STD/HIV and pregnancy prevention. Appropriate methods of contraception together with instruction on use should be made available. 10. Annual health guidance should cover tobacco, alcohol, other abusive substances, and anabolic steroids. 11-23. See Table 2
Screening Immunizations	24. Immunization status of all adolescents should be current and in compliance with the Advisory Committee on Immunization Practices, including bivalent dT, trivalent MMR, and Hepatitis B for all adolescents involved in any high-risk behavior.

Table 2

The GAPS recommendations: screening

Scale	Number of items	Issues
Biomedical screens	6	• Immunization history • Family health history • Temperature • Height • Weight • Blood pressure
Physical health screens	5	• Exercise habits (fitness) • Dietary habits (obesity, nutrition) • Body image and dieting • Accidental injury risk (seatbelts, etc.) • Injury risk due to violence (fighting, etc.)
Psychosocial health screens	5	• Adjustment to puberty, adolescence • School adjustment, learning disabilities • Relationships • Depression, suicide • Abuse (emotional, physical, sexual)
Substance use screens	4	• Tobacco • Alcohol • Illicit drugs • Misuse of over-the-counter and prescription drugs
Sexual behavior screens	1	• Sexually active? • If yes, follow-up: –Contraception practices –Pregnancy history –STD history and screen –Number of partners –Sexual orientation –(If risk factors) HIV screen

the sociobehavioral problems that pose the greatest threat to the health of America's youth. MM

ACKNOWLEDGMENT

This paper was supported in part by MCJ-000985-15, the Adolescent Health Training Program; MCJ-273A-03-01, the National Adolescent Health Resource Center; and a grant from Medica Foundation.

Robert Blum is a professor in and director of the Division of General Pediatrics and Adolescent Health, Department of Pediatrics, University of Minnesota, Minneapolis. Trish Beuhring is research associate at the National Adolescent Health Resource

Center, Division of General Pediatrics and Adolescent Health, University of Minnesota.

REFERENCES

1. Blum RW. Contemporary threats in adolescent health in the United States. *JAMA* 1987;257:3390-5.
2. Elster A, Kuznets N. AMA guidelines for adolescent prevention services (GAPS). Chicago: American Medical Association, 1992.
3. Sells CW, Blum RW. Current trends in adolescent health. *Am J Public Health* 1995 (to be published).
4. Resnick MD, Harris LJ, Blum RW. The impact of caring and connectedness on adolescent health and well-being. *J Pediatr Child Health* 1993;29(Suppl 1):S53-S9.

**Family Practice**

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 155 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Pediatrics
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember. Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

**To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)**

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded on credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

ANNOUNCEMENTS

• • • • •

MARK YOUR CALENDAR FOR THE 1995 MMA ANNUAL MEETING

Plan to attend the 1995 MMA Annual Meeting on September 27, 28, and 29 in Rochester.

• • •

MMA KICKS OFF CAMPAIGN AGAINST MEDIA VIOLENCE

The MMA has launched a major campaign warning that media violence is a health hazard for kids. If you would like to receive bumper stickers, copies of the brochure, "10 Tips for Parents to Stop the Media Violence," or posters to display in your office, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875.

• • •

GROWTH LIMIT IS ANNOUNCED

The April 24 *State Register* announced that the projected growth limit on health care expenditures for 1996 is 7.4 percent.

• • •

MMA FORMS MEDICAL EDUCATION TASK FORCE

The MMA has formed an ad hoc task force on medical education, chaired by Diane Dahl, M.D. The task force began meeting in March to consider issues related to undergraduate and graduate medical education and work-force planning. The goal is to develop policy recommendations to present to the 1995 MMA House of Delegates in September.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Wins Repeal of RAPO, Other Major Goals

At the eleventh hour, the MinnesotaCare bill passed. On May 21, the last day of session, both the House and Senate passed a compromise version of the health reform bill. The final bill includes many of the major provisions in the Minnesota Medical Association's bill, including repeal of the regulated all-payer option (RAPO), the MMA's data collection and utilization review provisions, and repeal of the requirement for the state to develop practice parameters. As part of the repeal of insurance reforms, it includes the MMA provision allowing premiums to vary because of age so insurance coverage doesn't become too expensive for young people. In addition, the bill prohibits the transfer of MinnesotaCare funds into the general fund and sets up a direct contracting pilot program in the Mankato area.

Passage of this bill is a significant victory for the MMA. It allows a variety of different health plans, including HMOs, indemnity insurance plans, co-ops, ISNs, and CISNs to compete in the marketplace and keeps the door open to expand eligibility for the MinnesotaCare program.

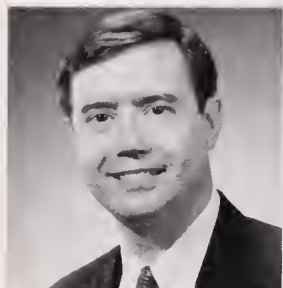
The MinnesotaCare bill had been stalled by controversy over abortion, triggered mainly by the standard benefits set section of the bill. After amendments restricting abortion were attached in both the House and Senate, the bills were tabled and appeared dead for the session. In an effort to break the stalemate, the MMA joined more than 20 organizations in urging the Legislature to

pass health care legislation this session. Paul S. Sanders, M.D., MMA chief executive officer, spoke at a news conference in St. Paul in support of the MinnesotaCare bill. Without taking a position on the abortion amendments, representatives of the MMA and other groups expressed the hope that the MinnesotaCare bill would not be bogged down by controversial issues but would be allowed to pass on its own merits. The MMA sent out a Legislative Alert asking members of the Legislative Network to call and write their legislators.

Following the show of support for health system reform, the Senate voted to remove the medical benefits set provisions from the MinnesotaCare bill and passed it on a 52-13 vote. The House bill remained stalled.

With only two weekdays left in the 1995 session, on May 19, Rep. Roger Cooper, DFL-Bird Island, presented to the House Rules Committee a compromise bill to replace the Senate MinnesotaCare bill. Cooper assured the committee this compromise would be acceptable to the governor and to Senate leaders, but he warned that if it were changed in any way, support would evaporate. For that reason, Cooper said, he would pull the bill if it were amended. He told the committee the Legislature did not have enough votes to override the governor's veto and, therefore, it would have to compromise on the eligibility level for the MinnesotaCare program. The governor had threatened to veto the bill unless its

Repeal continued on page 36



Viewpoint

...

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Could One Wrong Decision Send You to Jail?

There is a worrisome trend to find a scape goat whenever things go wrong. A chilling example is the move to criminalize medical decisions that lead to a bad outcome.

An early indication of this trend was the 1992 decision of a New York court that Gerald Einaugler, M.D., should go to jail for failing to hospitalize a nursing home patient as soon as he realized his mistake in ordering that she be fed through a dialysis catheter, which he thought was a feeding tube. Einaugler immediately consulted with the patient's nephrologist and monitored her condition, but he didn't hospitalize the woman for 10 hours. This decision proved to be his undoing.

The patient was 78 years old, suffered from diabetes, end-stage renal disease, cardiovascular disease, retinopathy, and organic brain syndrome. There was no autopsy to determine the cause of death, but the medical examiner testified at the trial that the woman died from peritonitis caused by feeding her through the catheter. Other experts disagreed.

Did the woman die because she wasn't hospitalized immediately? The jury thought so. For delaying hospitalization, Einaugler was convicted of two misdemeanors—reckless endangerment and neglect—and was

sentenced to weekends in jail for one year at Rikers Island. As the *Monitor* goes to press, his sentence is on hold pending a hearing before a U.S. District Court.

At worst, Einaugler may not have practiced medicine up to the best standards of medical practice, but it seems incredible that he should be thrown in jail. His state licensing board did not censure him, but stated he made the "wrong decision in selecting from the constellation of options open to him." Errors in medical judgment are usually dealt with by professional licensing boards or through civil malpractice litigation. This was the first such case to be criminally prosecuted, but not the last.

Recently, a medical laboratory in Milwaukee was charged with reckless homicide for failing to diagnose the cervical cancers that killed two women. An expert testified that the lab missed unmistakable signs of cancer. This was a tragic error and there should be consequences. But is a mistake a "homicide?" No matter how terrible the outcome, there was clearly no intent to do evil.

Publicity surrounding the lab case focused on fears that a desire to control costs had undermined quality of care. CBS reported that investigators found the lab was running Pap smears at about three times the

rate that experts believe is prudent and said that cancer specialists worry that health plans and laboratories are in too great a rush to cut costs.

Certainly there should be accountability for a high rate of errors and for policies that make errors likely. But moving into the criminal realm will have a paralyzing effect on health care. As clinics and labs try to design policies that are cost effective and provide good care for their patients, they will never be able to reduce the risks to zero and guarantee 100 percent accuracy.

We should strive for perfection, but we won't achieve it. We should use the best standards of medical practice and support clinical policies and practice parameters that promise a high level of care, but we can't guarantee there will never be a bad outcome. Going to jail should not be the penalty for a mistake. It is a cruel irony that people who devote their careers to saving lives should be treated as criminals if they fail.

What will be the result of criminalizing medical decisions? Clinics and labs will be unable to hold down costs if they fear prosecution for policies that don't provide a good outcome in every case. Efforts to practice more efficient medicine will collide with fear of criminal prosecution. Physicians are often expected to weigh costs and benefits for an entire patient population. Faced with jail, however, they may avoid taking chances and may order tests or procedures that have only a slight chance of being beneficial or may hospitalize patients at the first sign of a problem. Physicians may even be reluctant to treat very old and ill nursing home patients.

Fear of this trend to criminalize medical decision-making led the Minnesota Medical Association to vigorously oppose the felony penalties for criminal neglect in the Vulnerable Adults bill. Fortunately, we were successful in removing the felony penalty, but physicians will have to remain vigilant about the criminalization issue.

.....

ANNOUNCEMENTS

• • • • •

**CALL NOW FOR A SUMMER
HEALTH CARE INTERN**

If you would like to have a high school student or post-secondary school student work as an intern in your clinic or hospital during the summer of 1995, sign up now. The MMA is putting together a list of clinics that would like to participate in the summer health care intern program.

This program is open to students between their junior and senior year of high school and those who have completed high school and plan to complete a two- or four-year health care degree program. The program allows them to explore a career in medicine by giving them hands-on experience at a hospital or clinic.

The employer must agree to provide a six- to 12-week position that allows formal exposure to the health care profession and must pay half the cost of the students wages of \$4.25 to \$6.00 per hour. Employers will be reimbursed by the state for the other half of the wages.

If your clinic or hospital is interested in participating in the summer intern program, call Wendy O'Donnell at the MMA, 612/378-1875 or 800/999-1875. For more information about the program, contact Naomi Bowman at the Minnesota Hospital Association, 612/331-5571 or 800/782-6920.

MMA Kills Felony Penalty in Vulnerable Adults Bill

In a major victory for the Minnesota Medical Association, the felony penalty for criminal neglect was stripped from the Vulnerable Adults bill on the floor of the House and the Senate.

In the House, Rep. Tim Pawlenty, IR-Eagen, successfully offered an amendment that keeps the penalty the same as in current law—a gross misdemeanor. Arguing in favor of eliminating the felony penalty, Pawlenty said that if physicians are going to be second-guessed on treatment decisions, they will have to run every test in the book to avoid prosecution. "Putting physicians' liberty at risk will have a dramatic impact on defensive medicine and on health care costs," he said.

Despite strong opposition from the Attorney General's office and the Minnesota Citizens Concerned for Life (MCCL), the MMA amendment passed with a strong majority. MCCL objections to reduction of the penalty came after the MMA opposed its efforts to ensnare the MinnesotaCare bill in controversial abortion amendments (see page 33).

The MMA's success in the House followed a similar victory in the Senate, where Sen. John Hottinger, DFL-Mankato, offered the amendment to reduce the felony to a gross misdemeanor. The felony offense is punishable by up to 10 years in prison and fines up to \$20,000. The penalty for a gross misdemeanor is up to one year in prison, fines up to \$3,000, and exclusion from the Medicare and Medicaid programs. The Vulnerable Adults bill, H.F. 598-Greenfield/S.F. 512-Spear, passed.

First enacted in 1980, the Vulnerable Adults Act is intended to protect patients in a hospital, nursing home, or other licensed facility as well as individuals with a physical, mental, or emotional dysfunction that impairs their ability to protect

themselves. Under current law, a person who intentionally fails to supply food, clothing, shelter, or other necessities to a vulnerable adult could be charged with criminal neglect, a gross misdemeanor. The Vulnerable Adults bill, as amended, will not change the definition or the penalty for criminal neglect.

The MMA victory followed a tremendous grassroots effort to convince legislators that the bill, as originally drafted, would not distinguish between caregivers who act in good faith and those who intend to do harm. An MMA "Call to Action" alerted the MMA's Legislative Network of physicians, many of whom contacted their legislators. MMA officers, members, lobbyists, and legal counsel explained the probable effects of this bill to legislators. They stressed that fear of prison could discourage family members as well as professional caregivers from caring for vulnerable adults. It could also increase the practice of defensive medicine and lead to higher health care costs. Senate and House staff told MMA lobbyists that the substantial volume of letters from physicians had a great impact on the outcome.

The MMA had earlier achieved other improvements in the Vulnerable Adults bill. As originally drafted, this bill would have made failure to report abuse of a vulnerable adult a felony. It is now a gross misdemeanor or to intentionally fail to make a report if the mandated reporter knows the maltreatment caused or contributed to a vulnerable adult's death or great bodily harm and either: 1) the failure to report causes or contributes to the death or great bodily harm, or 2) the failure to report protects the reporter's interests. In other cases, failure to report is a misdemeanor. • • • • •

Repeal continued from page 33

provision to raise eligibility to 150 percent of poverty (\$11,040) were removed. If the bill failed to pass or were vetoed, Coopers said that 85,000 people, 45,000 of them children, would be without insurance as of July 1995.

The Rules Committee debated abortion-related amendments for three hours before passing the bill on a 14-3 vote. House Speaker Irv Anderson, DFL-International Falls, was one of the "no" votes. Before the bill passed, the committee defeated amendments that would have strengthened the anti-abortion language and brought the bill closer to the House version, which stalled.

The compromise bill does not

allow the MinnesotaCare program to pay for elective abortions. Defending the compromise, Coopers said he was caught between a rock and a hard place. "I consider myself pro-life, but the reality is, I won't get everything I want. We're a long way from universal coverage, but this bill moves us closer; we're a long way from ending elective abortions, but this bill moves in that direction."

The committee defeated an amendment proposed by Anderson to delete the entire Senate bill except for a provision to continue funding for the MinnesotaCare program for two years and leave all the policy decisions until next session. Urging the committee to defeat this amendment, Cooper asked, "What will you say to Minnesota physicians who are

on the fence about whether to stay in Minnesota if RAPO remains?" The compromise bill passed and was referred to the House Ways and Means Committee, which sent it to the full House. Following the failure of attempts to attach stronger anti-abortion amendments, the bill passed 121-13.

After the governor's office assured the bill's author, Sen. Linda Berglin, DFL-Minneapolis, that expansion of the MinnesotaCare program to 135 percent of poverty would really take place if possible, the Senate passed the compromise bill on a 45-18 vote. As *The Monitor* goes to press, the governor is expected to sign it. • • • • •

Major Provisions of the MinnesotaCare Bill

• • • • • THE MINNESOTACARE BILL will accomplish the following:

- Repeal the regulated all-payer option, RAPO.

- Prohibit transfer of money from the health care access fund to the general fund.

- Provide that after October 1, 1995, the commissioner of human services may expand eligibility for individuals who earn up to 135 percent of the federal poverty level if financial management requirements are met.

- Require a report and recommendations about implementation of the growth limits to be made to the Legislature.

- Repeal the standard benefits set, exclusions, and cost-sharing provisions.

- Repeal the mandate that all Minnesotans have insurance by 1997.

- Set the goal of reducing the number of uninsured so that by the year 2000, less than 4 percent of the population will be uninsured.

- Freeze insurance reforms, hold community rating at the

present level, eliminate further moves to guaranteed issuance in the private market.

- Provide that no health plan or co-op can be required to cover abortion.

- Provide that no public funds may be used for coverage of abortion under MinnesotaCare except when the life of the woman would be endangered or when substantial and irreversible impairment of major bodily function would result if the fetus were carried to term, or when the pregnancy is the result of rape or incest.

- Enact MMA data provisions, including repeal of the practice parameter committee and clarification of the data collection and analysis responsibilities of the Health Data Institute and of the Department of Health.

- Create a voluntary prescription drug purchasing program for low-income seniors.

- Require a study and hearings on the impact of managed care on the quality of life and care of terminally ill or chronically ill or disabled

patients (report is due December 15, 1996).

- Enact most of the MMA's utilization review provisions. Plans must disclose UR criteria to physicians and patients upon request. Practicing physicians must be involved in developing clinical criteria, and the criteria must be reviewed each year. Prior authorization for emergency care is prohibited. Minnesota's UR law applies to workers' compensation.

- Enact several MMA provisions to improve health plan accountability. Networks cannot be designed to exclude people with expensive health care needs. All plans must participate in state risk adjustment. Out-of-network emergency care must be covered by health plans.

- Create a demonstration project that allows direct contracting with a qualified employer or self-insured employer plan for health provider cooperatives established before May 1, 1995, whose members provide services in Sibley, Nicollet, Blue Earth, Brown, Watonwan, Martin, Faribault, Waseca, and Le Sueur counties. Contracts may become effective January 1, 1996. This demonstration project sunsets December 31, 1999.

.....

LEGISLATIVE SUMMARY

MMA BLOCKS INTRODUCTION OF AG'S REPORTING BILL

At the beginning of session, the attorney general was expected to introduce a bill to allow health-related licensing boards to provide unsubstantiated complaint data and confidential data from patients' medical records to state and federal criminal enforcement authorities. The proposal would have allowed the BMP to disseminate information from the personal medical record of the physician, including data related to drug addiction, alcoholism, mental illness, and other highly personal data. The MMA strongly opposed these proposals, and the legislation was never introduced.

.....

BMP INSURANCE SETTLEMENTS BILL IS SIGNED

The Insurance Settlement bill, S.F. 95-Piper/H.F. 226-Kelley, which was proposed by the Board of Medical Practice, has been signed into law. This law requires hospitals and other organizations that provide malpractice coverage for physicians or other health professionals to report all malpractice settlements and awards to the BMP. Reports must include the name, the allegations in the complaint, and the dollar amount of the settlement. The MMA opposed this bill.

.....

BMP DISCIPLINARY ACTION ACT IS IMPROVED

The BMP Disciplinary Action bill, S.F. 72-Piper/H.F. 231-Kelley, passed and has been signed by the governor. Before the bill passed, however, the MMA succeeded in convincing legislators to attach an amendment that improves this legislation. As originally written, the bill would have automatically suspended the license of a Minnesota physician or other licensed health care professional convicted of a

felony that is reasonably related to the practice of medicine. At the urging of the MMA, the bill was amended to require that the felony be related to patient care rather than to the practice of medicine. The MMA argued that disposal of hazardous waste is a felony related to the practice of medicine, but it would have no impact on patient care. Another improvement requires the BMP to hold a hearing to determine whether the automatic suspension should be continued. The law will also permanently revoke the license of a doctor convicted of a felony-level criminal sexual conduct offense. This law is effective for convictions after March 28, 1995. In addition, the law allows the BMP to take disciplinary action against a doctor or health professional who fails to repay a state or federal student loan.

.....

CAPITATION BILL PASSES

A modified version of a bill, H.F. 193-Huntley, calling for one statewide capitation rate for Medical Assistance, was included in the Omnibus Health and Human Services funding bill, which has passed. Currently the state uses three base capitation rates: Hennepin County, other urban, and other rural. The new provision requires the non-metropolitan capitation rate to be 85 percent of the metropolitan rate. This would mean an inflationary increase of approximately 2 percent for Hennepin County, 6 percent for the rest of the metropolitan area and 15 percent for the rural area. The bill also calls for an advisory group to develop capitation rates based on appropriate criteria rather than on historical charges. The MMA supported this proposal, which responds to a resolution, adopted by the 1994 MMA House of Delegates, directing the MMA to work aggressively for geographic

equality in General Assistance Medical Care and Medicaid capitation rates.

.....

CHIROPRACTIC BILL IS DEAD

A strong grassroots lobbying effort by the MMA blocked the chiropractors' attempt to win legislative authorization to perform the required biennial physical examinations for truck drivers. The Minnesota Chiropractic Association initiated this bill in response to the Minnesota Department of Transportation's statement that a physical examination performed by a chiropractor does not satisfy the federal requirement. The MMA told lawmakers that chiropractors have neither the training nor the experience to perform an adequate exam. The bill, S.F. 233-Vickerman/H.F. 408-Cooper, died in committee.

.....

CIGARETTE TAX BILLS FAIL

The MMA strongly supported a number of proposals to raise the cigarette tax, pointing out that a statewide poll found nearly 65 percent of Minnesotans support a higher tax on tobacco. Despite vigorous lobbying by the MMA, the Smoke Free 2000 Coalition, and other anti-smoking activists, the tobacco tax bills failed. Republicans had vowed "no new taxes," and DFLers feared being labeled "tax-and-spend" Democrats. This anti-tax mood, coupled with the governor's veto threat, killed the bills. The MMA supported S.F. 1080-Price/H.F. 1321-Lourey, which called for a one-time 40-cent tax to fund smoking prevention programs and the MinnesotaCare program. The proposal failed. There was also an attempt to link a higher cigarette tax with a lower provider tax. This proposal to raise the cigarette tax by 25 cents and lower the provider tax

continued on page 38

.....

LEGISLATIVE SUMMARY

to 1 percent, S.F. 1080-Kiscaden/H.F. 1321-Lourey, was offered as an amendment to the MinnesotaCare bill but was not accepted. The MMA strongly supported this attempt.

.....

BILLS TO REDUCE CHILDREN'S ACCESS TO TOBACCO STALLS

The MMA supported a bill, proposed by Sen. Ember Reichgott Junge, DFL-New Hope, and Rep. Ann Rest, DFL-New Hope, that would have required stores that sell tobacco to be licensed by the local government, required compliance checks, and set penalties for violations of the law. This legislation died, but many of its provisions to keep children from buying cigarettes were amended onto the tobacco industry's bill, S.F. 558-Sams.

Originally, this proposal called only for a training program for tobacco retailers, and it would have preempt-

ed stronger local ordinances. At the urging of the MMA and the Smoke Free 2000 Coalition, however, the Senate adopted amendments to this bill that would have required licensing for stores that sell tobacco, set penalties on selling tobacco to minors, required random checks of compliance with the law, set up a training program for tobacco retailers, and banned payments to stores for displaying cigarette advertisements. Significantly, the amended bill stated that it would *not* preempt stronger local ordinances. The Senate bill passed, but its companion bill, H.F. 708-Simoneau, which did not include the amendments, stalled in the House. This issue is expected to be back next year.

.....

MMA DEFEATS MA COPAY

The MMA successfully opposed a provision in the House Welfare bill

that would have reduced provider reimbursement by \$5 for outpatient services to Medical Assistance patients and added a \$5 copay to be collected by the provider. The MMA argued that many MA patients would not be able to afford the copay and would avoid seeking necessary care, or the physician would have to pay the copay. The bill specifically stated that a provider could not deny care because of failure to pay the copay. At the urging of the MMA, the copay was removed from the bill.

.....

DRUG PURCHASING BILL FAILS

Repeated attempts by Sen. John Marty, DFL-Roseville, to pass the Senior Federation's drug purchasing bill this session failed, but the MinnesotaCare bill does include a voluntary drug purchasing program

Join an MMA Committee

..... SERVING ON AN MMA committee is an excellent way to keep up-to-date on interesting issues and to voice your concerns and opinions. The MMA benefits greatly from the committee members' generous contributions of time and expertise.

The MMA Committee on Bylaws, Committees and Membership is beginning the process leading to appointment of members of the MMA's standing committees for terms beginning January 1, 1996. The committees are: Accreditation and Continuing Medical Education; Administration and Finance; Bylaws, Committees and Membership; Communications; Ethics and Medical/Legal Affairs; Legislation; Medical Practice and

Planning; Minority Affairs; Professional Liability; Public Health and Preventive Medicine; Women Physicians; and Workers' Compensation.

MMA members are eligible to serve on one committee at a time for a maximum of six consecutive years. Committee terms are for two years, except for the Committee on Accreditation and CME, which has three-year terms. Trustee district representation on each committee is based on the total number of members in the district. Most committees meet an average of four times a year.

The committee appointment process begins when each county medical society nominates candidates from its membership to fill vacancies for the upcoming year. Trustees in each district review and submit the

slate of nominees to the Committee on Bylaws, Committees and Membership, which nominates candidates for any remaining vacancies and forwards its recommendations to the MMA Board of Trustees for ratification.

In addition, the Hospital Medical Staff Section, the Young Physicians Section, the Resident Physician Section, and the Medical Student Section appoint designated committee members annually to serve on select committees.

To be considered for appointment to a committee, please call your component medical society or call Jane Phillip at the MMA at 612/378-1875 or 800/999-1875. She can also give you more information about the activities of each committee and about the appointment process.

.....

LEGISLATIVE SUMMARY

that would allow low-income seniors to buy prescription drugs at discounted prices.

The MMA opposed the original bill SF-410-Marty, which would have imposed a statewide drug formulary and authorized the state to negotiate contracts for all pharmaceutical drugs. The MMA cautioned legislators that this bill might keep people from getting the specific medications they need. Faced with stiff opposition from the MMA and others, Marty amended his bill to make participation in the state purchasing pool voluntary. But the bill, which still included a controversial provision requiring hospitals and health plans to disclose all drug contract prices, including discounts and rebates, was never heard in any House committee.

.....

MMA OPPOSES CUTS IN GAMC REIMBURSEMENT

The conference committee on the Omnibus Health and Human Services bill, S.F. 1110-Samuelson, reduced the proposed "rateable reduction" on all General Assistance Medical Care (GAMC) outpatient and inpatient services from 5.4 percent to 4 percent. The bill, including this slight improvement over the House version, passed. The MMA strongly opposed any reduction in provider reimbursement for GAMC services, arguing that cuts would widen the gap between public program rates and the market rate. Lower GAMC reimbursements will reduce access and increase cost shifting. The situation will become even worse if, as expected, the federal government turns more responsibility for the Medicaid program over to the states. It is estimated this cut in physician reimbursement will save the state \$1.8 million over a two-year period.

.....

MMA SUPPORTS UMD SCHOOL OF MEDICINE EXPANSION

The MMA supported the bill, H.F. 690-Cooper, that would expand the University of Minnesota-Duluth School of Medicine from a two-year to a four-year program. This bill failed, but some planning money was allocated to UMD in the MinnesotaCare bill.

.....

PRESCRIBING BILL IS SIGNED INTO LAW

The governor signed the bill S.F. 543/H.F. 612, which requires health insurance plans that cover prescription drugs to pay regardless of whether the drug was prescribed by a physician, a nurse practitioner, or a physician assistant.

.....

BILL TO LICENSE ACUPUNCTURISTS PASSES

A bill requiring Minnesota acupuncturists to be licensed by the state and regulated by the Minnesota Board of Medical Practice has been signed into law. Currently, the state does not require training or licensing for acupuncture even though there are reported to be 50,000 acupuncture treatments performed each year in Minnesota. This bill, H.F. 446-Leppik, prohibits the practice of acupuncture after June 30, 1997, by anyone not certified by the National Commission for the Certification of Acupuncturists or grandfathered in under the bill. It does not apply to physicians and other licensed health care professionals who perform acupuncture. During a two-year phase-in period beginning July 1, 1995, acupuncturists can qualify for a state license without national certification if they have practiced at least three years between July 1, 1991, and June 30, 1995; have treated at least 100 different patients

each year, and have conducted 500 procedures.

.....

BILL TO REGULATE PAs PASSES

A bill, S.F. 258-Piper/H.F. 452-Kelley, passed, enacting in statute the Board of Medical Practice regulations for physician assistants that currently exist in rules. The bill's progress had been blocked by certified registered nurse anesthetists, but it moved forward after Rep. Steve Kelley, DFL-Hopkins, successfully offered an amendment to limit the ability of PAs to administer anesthesia. The amendment prohibits PAs from administering a spinal block, an inhaled anesthetic, or from injecting any anesthetic except a local during an operating room procedure. The MMA supported this bill and did not believe the amendment was necessary.

.....

MMA DEFEATS PHYSICAL THERAPIST LICENSING BILL

The MMA successfully opposed a bill, H.F. 757-Cooper/S.F. 614-Piper, that would have licensed physical therapists and created a separate licensing board for them. Physical therapists are registered by the Board of Medical Practice and are allowed to treat patients for up to 30 days without a physician's referral. The bill never received a hearing.

.....

MMA DEFEATS DISCOUNTS FOR WORKERS' COMP FEES

The MMA strongly opposed a proposal in the House version of the Workers' Compensation Reform bill, H.F. 642-Winter, that would have allowed certified managed care plans to discount provider fees below the workers' compensation fee schedule. The Senate bill did not contain the

continued on page 40

.....

LEGISLATIVE SUMMARY

provision allowing discounted fees. The MMA successfully lobbied to have this provision deleted from the House bill as well.

.....

SNOWMOBILE HELMET BILL STALLS

A bill, S.F. 605-Vickerman, which would require snowmobilers to wear helmets, passed the Senate and stalled in the House. The MMA supported this bill, which is similar to a provision in the MMA Quality and Coverage bill.

.....

SEAT BELT BILL FAILS

A bill, H.F. 474-Greenfield/S.F. 409-Berglin, that would allow a police

officer to stop a motorist for not wearing a seat belt died in committee. The MMA supported this bill, which was similar to a provision in the MMA bill.

.....

MMA PRESSES FOR TORT REFORM

The MMA's tort reform provisions were included in H.F. 589-Leppik/S.F. 578-Hottinger, but these bills failed to meet the first committee deadline. The MinnesotaCare bill includes an amendment that asks the attorney general to make recommendations due in 1996 on how to reduce costs. The provision specifically asks that the study look at California's experience in enacting

tort reform. The MMA tort reform provisions are based on California's Medical Injury Compensation Reform Act (MICRA).

.....

X-RAY TECHNICIAN BILL IS SIGNED

The MMA supported legislation requiring a minimum level of education for all x-ray machine operators in Minnesota. The bill H.F. 1003-Huntley/S.F. 1075-Piper, initiated by the Minnesota Department of Health, will grant the MDH authority to develop rules requiring an appropriate level of educational training for all x-ray operators. This legislation has been signed into law.

.....

NATIONAL NEWS

SENATE REJECTS MEDICAL LIABILITY PROPOSALS

Despite vigorous lobbying by the American Medical Association, joined by the MMA and other state medical associations, the U.S. Senate did not adopt a cap on non-economic damages in medical liability lawsuits in its product liability reform bill, H.R. 956. Sen. Rod Grams, IR-Minn., voted for the medical malpractice provisions. Sen. Paul Wellstone, DFL-Minn., voted against them. The bill, as it passed the Senate, confines the limits on punitive damages to product liability cases. The House version of the bill, however, does apply to medical liability cases. It calls for a \$250,000 cap on non-economic damages and joint and several liability reform for non-economic damages. A conference committee will resolve the differences between the House and Senate bills.

.....

SUPREME COURT UPHOLDS NEW YORK'S PROVIDER TAX

The U.S. Supreme Court ruled on April 26 that a New York state surcharge on hospital bills submitted by patients insured by employer-sponsored health benefits plans, does not violate the Employee Retirement Income Security Act (ERISA), as the Travelers Insurance Company had charged in its lawsuit. The surcharge provisions do not relate to employee benefits plans, the court wrote, and thus do not trigger ERISA preemption. This ruling overturns a 1993 decision by the 2nd U.S. Circuit Court of Appeals, which had caused some confusion because it conflicted with a decision by the 3rd U.S. Circuit Court of Appeals that ERISA did not pre-empt a similar New Jersey law. The Supreme Court ruling strengthens the state of Minnesota's position that the 2 percent provider tax does not violate ERISA and that it may be passed through to self-insured health plans.

The Monitor
JUNE 1995
...

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren
...

Look for this seal



The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBer), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this Seal. This Seal is your assurance that the product or service offered meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the  the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR... physicians working for physicians.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

A Quiet Crisis

The Minnesota authors of "America's Children: Triumph or Tragedy" (APHA, 1994) call for an overhaul of a fragmented system that jeopardizes our nation's children.

Patsy Stinchfield, R.N., M.S., C.P.N.P.

"A 14-year-old girl visited a medical clinic in Grafton, West Virginia. She complained of debilitating abdominal pain. Her eyes were sunken and her belly was bloated. As her initial interview concluded, she revealed that she and her brothers and sisters would rummage through the dumpsters of local supermarkets in an effort to salvage their nightly dinner."

"Children are our greatest natural resource, and we ignore their development at our peril. It is through them that we invest in the future of the economy, in the nation's future security and in its future social health and stability."

—Alan Pifer as quoted in "America's Children: Triumph or Tragedy"

As I write this review, the United States is observing a national day of mourning after the bombing of a federal office building in Oklahoma City. The unprecedented tragedy rivets the country. The collective somber mood is punctuated by anger, sorrow, and disbelief. Mourning the losses, particularly of the babies and young children, has brought together people of all races, religions, and social classes in a national call to action. This incident of domestic terrorism has served as a wake-up call out of which a commitment is rising to protect the innocent from such a devastating event in the future.

There is another tragedy that every day in every state of the union also affects babies and children. It is a quiet crisis, an insidious tragedy that is going unnoticed by many. The book, "America's Children: Triumph or Tragedy" by Minnesota authors Charles N. Oberg, M.D., M.P.H., Nicholas A. Bryant, and Marilyn L. Bach, Ph.D., not only delivers the information about the tragedy of our children, but also provides a blueprint for change—a paradigm shift in the way American society cares for its children.

This excellent 94-page book succinctly describes a crisis that jeopardizes America's future; the nation's children—our greatest natural resource—are growing ever more poor and disadvantaged. "America's Children" illuminates the many federal, state, and local

policies of the 1980s, largely economic, that set the course for a dysfunctional, fragmented system of children's services that fails to meet the needs of all children.

The book introduces us to the crisis by noting two juxtaposing trends that are creating the need for a new children's health and welfare system; namely, the aging of America along with the impoverishment of its children. Fourteen million children are living in poverty; in 1992, the poverty rate for children was 21.1 percent. By the year 2000, older Americans will be more prevalent than the younger generation for the first time in history. By 2034, only two workers will contribute to Social Security for every retiree, according to projections. "America's Children" is chock-full of such facts; bringing them to light is the book's strength. "America's Children" describes in detail the many interconnected needs of children, highlighting six: economic security, medical care, affordable shelter, good nutrition, high-quality child care, and early education.

The authors describe their vision of an "Integrated Children's Network," a functional system of interlocking gears coordinating the above health and welfare services for all children. The goal is to help disadvantaged children become autonomous, productive adults. Ignoring their needs puts these children's medical, cognitive, and socioemotional developmental well-being at risk, diminishing their future contributions to society.

The authors advocate for the following principles in redesigning the current system into an Integrated Children's Network: a single unified application process with a sin-

gle point of entry, access to all six types of health and welfare services for children who meet eligibility requirements for any one of the six services, and standardized financial eligibility criteria making services available to all those requiring assistance, including corridor poor and the middle class.

Streamlining and integrating existing services rather than creating more bureaucratic layers would allow for meaningful and lasting welfare reform. Among the 20 specific recommendations the authors identify are the following:

- eliminating the discrepancy between the states' determination of AFDC "standard of need" and payment levels to families;
- developing a refundable child tax credit based on a sliding fee scale using the federal poverty threshold;
- phasing out the employer health insurance coverage system and replacing it with a single-payer program for maternity and child health care;
- disallowing health care providers to dismiss patients because of their economic status—all providers would be required to treat privately and publicly financed patients;
- enacting the Child Health Insurance Reform Program through legislation requiring preventive care health services in all insurance packages;
- joining housing and welfare agencies with the private sector to offer affordable shelter that is secure and decent and focuses on the transition to independence;
- ensuring full funding of the WIC program to allow all eligible families earning less than 275 percent of the federal poverty level to receive WIC benefits;
- ensuring full access to the school break-

fast and school lunch programs for those eligible;

- increasing allocations for federal funding of high-quality child care programs;

- defining and monitoring minimum standards for child care facilities, just as we have standards for inspecting our food, drugs, and water;

- upgrading salaries and conditions for child care workers in order to provide high-quality care and low turnover rates;

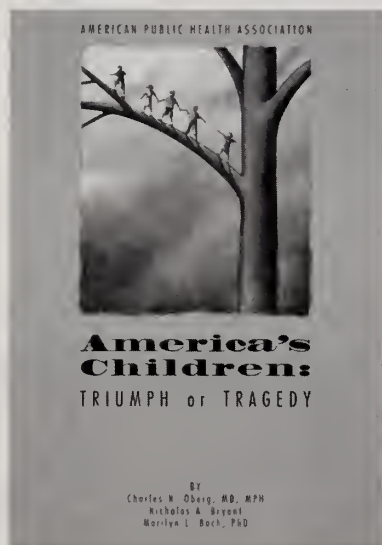
- investing in new and innovative methodologies in child care research and evaluation;

- providing greater funding to the Head Start program to increase training and technical assistance, to im-

prove facilities, to reduce staff-to-child ratios, and to conduct better outcome evaluation studies.

"America's Children" should be mandatory reading for all who care for and about our children and their future, especially those involved in the development of public policy. We must harness the current concern for the tragedy of children's lives lost in Oklahoma City and galvanize the country, as the authors say, to a "new social will." We must rise above this insidious problem and advocate for a collective commitment to triumph over daily tragedy for a better tomorrow. Let us waste no time. **MM**

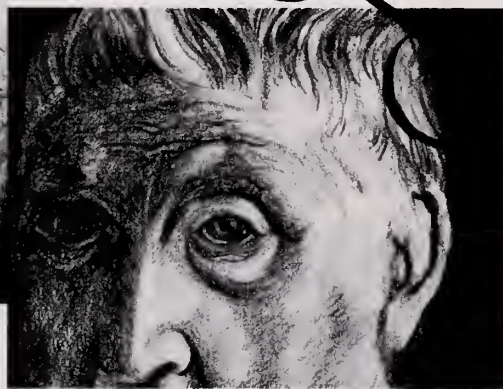
Patsy Stinchfield is a pediatric nurse practitioner at Children's Health Care—St. Paul. She has long been an advocate for children and families, working with the homeless, children with HIV, and Minnesota's poorly immunized communities. She is the mother of two preschoolers and hopes for a brighter future for all children.



"Mary, a mother of three children ages six, eight, and 12, is the head of a family that also includes a disabled sister. The five of them lived in a private market apartment complex in Chicago. They heard gunfire every night. Her children were propositioned and offered drugs in the elevator. She quit her job with no notice. She arrived in St. Paul and went to a shelter and signed up for AFDC. When asked why she came to St. Paul, she answered: 'Because I don't know anybody.'"



A COMMITMENT TO
Quality



STARTS WITH

Quality Peer Review

The Minnesota Medical Association is proud to announce its Peer Review Consultation service. This program, tailored to meet state and federal guidelines, is designed for use by hospitals, clinics and other organizations that need peer review by an impartial third party.

Reviewing physicians

- ♦ are either board certified or eligible in appropriate specialties or subspecialties
- ♦ have been trained in objective peer review procedures
- ♦ will conduct reviews on-site or off
- ♦ will provide an advisory report containing background information, findings of fact and conclusions

To obtain confidential peer review consultation services, call the MMA and ask for Peer Review Consultation Services. In the Twin Cities call 378-1875. Outside the metro area call toll free, 1-800-999-1875.

The MMA is committed to helping you maintain and improve the quality of health care.

Call us today.



MMA

Minnesota Medical Association

In Memoriam

Frank J. Ankner, M.D.

Rush Medical College, 1938

Born: 1914, Died: Feb. 12, 1995



Maurice W. Beers, M.D.

University of Minnesota, 1972

Born: 1939, Died: Dec. 3, 1994



Titus P. Bellville, M.D.

Medical College of Wis., 1941

Born: 1914, Died: Feb. 28, 1995



William L. Bendel, M.D.

Tulane University, 1944

Born: 1921, Died: Feb. 11, 1995



Leonard Borowicz, M.D.

University of Minnesota, 1939

Born: 1916, Died: Nov. 5, 1994



Ray Camp, M.D.

University of Nebraska, 1944

Born: 1920, Died: Nov. 1994



Catherine Corson West, M.D.

University of Minnesota, 1936

Born: 1902, Died: Apr. 10, 1995



William H. Dearing, M.D.

University of Pennsylvania, 1934

Born: 1908, Died: Dec. 4, 1994



Murray P. Ersfeld, M.D.

University of Minnesota, 1940

Born: 1911, Died: Jan. 26, 1995



Henry Fisketti, M.D.

University of Minnesota, 1937

Born: 1909, Died: Feb. 17, 1995



Joseph Geller, M.D.

University of Minnesota, 1957

Born: 1922, Died: April 3, 1995



Benjamin R. Geurs, M.D.

University of Minnesota, 1943

Born: 1917, Died: Nov. 9, 1994



LeRoy F. Gies, M.D.

University of Minnesota, 1965

Born: 1927, Notified: March '95



Isadore Goldberg, M.D.

University of Minnesota, 1923

Born: 1900, Died: March 8, 1995



John Amberg Haugen, M.D.

University of Minnesota, 1930

Born: 1906, Died: Dec. 11, 1994



Philip G. Hoeper, M.D.

University of Minnesota, 1930

Born: 1907, Died: Jan. 5, 1995



Robert H. Kaplan, M.D.

University of Michigan, 1974

Born: 1948, Died: April 2, 1995



Helen M. Kelly, M.D.

University of Minnesota, 1959

Born: 1918, Died: Nov. 30, 1994



Carl L. Lundell, M.D.

University of Minnesota, 1943

Born: 1915, Died: Jan. 26, 1995



Gordon L. McKinlay, M.D.

University of Chicago, 1950

Born: 1925, Died: April 2, 1995



Roger P. Michels, M.D.

University of Minnesota, 1943

Born: 1917, Died: Sept. 13, 1994



John C. O'Brien, M.D.

University of Illinois, 1944

Born: 1920, Died: March 13, 1995



John Otto Holt Peterson, M.D.

University of Minnesota, 1963

Born: 1932, Died: Feb. 7, 1995



Arne D. Rydland, M.D.

Medical College of Wis., 1944

Born: 1919, Died: Feb. 18, 1995



Carl A. Schwartz, M.D.

University of Pennsylvania, 1947

Born: 1923, Died: Nov. 28, 1994



Harold H. Scudamore, M.D.

Northwestern University, 1946

Born: 1915, Died: Dec. 15, 1994



Donald B. Simonson, M.D.

Rush Medical College, 1937

Born: 1910, Died: Jan. 5, 1995



William T. Smith, M.D.

University of Kansas, 1946

Born: 1922, Died: Oct. 22, 1994



Maurice H. Stauffer, M.D.

University of Kansas, 1941

Born: 1915, Died: April 12, 1994



Robert L. Strom, M.D.

University of Iowa, 1955

Born: 1930, Died: Jan. 10, 1995



David John Vesall, M.D.

University of Minnesota, 1975

Born: 1949, Died: Feb. 16, 1995



Stanley P. Wesolowski, M.D.

Loyola University, 1943

Born: 1914, Died: Mar. 21, 1995



John E. Westrup, M.D.

Medical College of Wis., 1939

Born: 1912, Notified: Nov. '94



REMAFEDI

(continued from page 7)

less, street kids, throwaways, runaways—don't speed up the maturation process. "We used to call that 'the school of hard knocks,' " he

says. "Well, it's not true. All it does is arrest a child's development."

This psychosocial dynamic poses a challenge to physicians, who must recognize that adolescent health care goes beyond medicine. The major causes of morbidity and mortality are not medical issues, by and large.

Accidents, suicide, homicide, and now AIDS—problems with social and mental health etiologies—are the leading killers of the young. That means physicians must be connected to professionals in other disciplines to provide the types of interventions that are necessary to handle difficult problems, Remafedi says.

Treating adolescents requires certain skills, he adds. "You have to get to know them, and you have to ask questions about different aspects of their lives that might be sensitive but are important to talk about." The issues include everything from sexuality to violence, the family, mental health, school performance, and general development. "That takes special skills," Remafedi says. "It also takes time."

The need to train physicians in those skills was officially acknowledged last fall, when the American Board of Pediatrics made adolescent medicine a board-certified subspecialty. But interest in the field preceded the board's recognition. Remafedi says the field was shaped by an older group of pediatricians who were interested in the health care of adolescents but never focused their careers on it. They trained a new generation to take care of teenagers. That generation included physicians like Blum, who formalized the training into a specialty area, which now includes practitioners like Remafedi.

While Remafedi sees a move to train all pediatricians in the care of adolescents, he says that physicians probably will need to make some distinctions between pediatricians who care for young children and those who care for adolescents.

Remafedi says he has always had to push to get his ideas accepted, but he has had the satisfaction of seeing many of them adopted, including the establishment of medical and supportive services for gay and lesbian youth across the United States, as well as the Youth and AIDS Projects.

YAP grew out of a proposal funded by the state in 1989 to create an AIDS prevention program for young men under age 21. Because some of the program's first clients already were infected with HIV, Remafedi

Principal Clinical Coordinator

The Foundation for Health Care Evaluation is seeking an extraordinary physician for an out-of-the-ordinary senior management position. We are looking for a Principal Clinical Coordinator to direct our statewide Health Care Quality Improvement Program activities. This person will provide vision and direction for staff and teams working with a program involving conducting pattern analysis of care and outcomes for the Minnesota Medicare population, and implementing quality improvement and education programs with hospitals and physicians throughout the state.

Board certification in allopathic or osteopathic specialty is highly desirable. Local medical practice experience and a master's degree in public health (MPH) or equivalent experience is preferred. The successful candidate will have substantial quality improvement/quality assurance experience in a hospital setting or substantial management experience in applied research activities. She/he must also possess the knowledge, credibility and experience to work directly with hospital and managed care administrative and medical staffs on clinical and statistical issues. The individual should have experience and interest in working with an interdisciplinary team in an applied research setting.

Technical skills should include:

- The ability to understand concepts of statistical analyses and to communicate these concepts clearly to hospital and managed care administrative and medical staffs in order to change practice and outcomes.
- Experience in the analysis of clinical practice and outcomes data.
- Familiarity with and commitment to continuous quality improvement techniques.
- Familiarity with the principles of epidemiology.
- Experience in making presentations to physicians.
- A broad range of knowledge of current clinical research and practice guidelines.

Applicants should submit a detailed résumé to:

Catherine Corbett
Director, Human Resources
Foundation for Health Care Evaluation
2901 Metro Drive, Suite 400
Bloomington, MN 55425

*FHCE has a smoke-free environment
and is an Equal Opportunity Employer.*

started thinking about the comprehensive array of medical and psychosocial services needed by young people who, he says, "bring so many problems along with their HIV." The result was a group of programs, including the cornerstone prevention project, HIV counseling and testing, health care, case management services, and school and community outreach. Remafedi, who is the clinic's only staff physician, follows about half of the infected youth. Others are referred to physicians throughout the community.

Now Remafedi is concerned that the changing political mood in the new Congress could jeopardize programs like YAP, and that resources for people with AIDS will be cut. Yet, whatever the future holds, young people can be confident that they have an advocate in their corner.

"I believe we all have a mission in life," says Remafedi. "We're here for some reason. If you do the best you can and pay attention when you get nudged by whatever is out there pushing us in the right direction, then you will find it."

Remafedi seems to have found it, so he must be paying attention.

"I try," he says.

MM

Miriam K. Feldman is a free-lance writer living in Minneapolis and a frequent contributor to Minnesota Medicine.

IT'S TIME WE CLEAR
THE AIR...TOGETHER.

**SMOKE
FREE
2000
COALITION**

For more information please call
612-338-8193.

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care - at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.

Employee Benefits Attorneys

2600 Eagan Woods Drive, #450

Eagan, MN 55121-1152

Practice limited to ERISA since 1988

Tel: 612-452-9322

Fax: 612-452-9355

TV VIOLENCE

(continued from page 15)

lence and in graphic detail. So-called action movies like "Rambo" and "The Terminator" are extremely violent and clearly aimed at children. A line of toys accompanies many such films, as do promotions at fast-food restaurants frequented by children.

Although most of these films are rated "R," younger audiences have no difficulty gaining access to theaters. Besides, it's only a matter of months before the films become available as rental videos or appear on cable television.

Violence as a theme has also invaded the domain of music marketed to young people. Much of this music degrades women and promotes bigotry. A spate of popular songs glorify gang membership and the violent behavior that is a part of it. Unfortunately, like the television producers, a growing segment of the music and music video industry has discovered that violence can be profitable. Again, the profits to be made become the

overriding concern.

The fast-growing video game industry in the United States is a multi-billion-dollar, overwhelmingly youth-oriented industry. The easy sell of violence has taken over this medium as well. Nintendo, for example, is the market giant. A study by the National Coalition On Television Violence showed that 80 percent of Nintendo games portray violence. In "Mortal Kombat," the best-selling video game of all time, the object is not just to kill your opponent, but to master the skills to do it more and more viciously.

Whatever form it takes, media violence is a major contributor to what has become a crucial public health issue. We have been confronted with serious public health problems before, and the medical profession has taken the lead in shaping public opinion and mobilizing collective action. A good example is the shift in society's attitude about tobacco. A generation ago, tobacco was not only acceptable, it was socially desirable. Television ads featured attractive models and celebrities touting this brand of cigarette or

that. Many of the characters in movies and television programs smoked. Then, during the '70s and '80s, armed with medical research, we as a nation determined that tobacco use was unhealthy and undesirable. Within a generation, the nation's collective attitude has changed. A carefully and aggressively pursued health campaign has altered society's values about tobacco. Education and constant reinforcement have reshaped public opinion. Today, many smokers feel they are members of a persecuted minority. Whether they are indeed "persecuted" is debatable, but they are clearly a dwindling minority, because the tide of public opinion has turned. The Minnesota Medical Association was and is a leading force in turning that tide in our state.

Now, declaring violence a public health threat, the Minnesota Medical Association has developed guidelines for helping parents reduce their children's exposure to media violence (see page 16). Minnesota physicians should discuss the guidelines with their patients and make them available in their offices and clinics. Because people respect and trust the advice of physicians, doctors are in a position to help confront the scourge of violence that is infecting our towns and cities. Medical and health professionals statewide can help save lives by joining the MMA's campaign to stop the violence. **MM**

David Walsh, Ph.D., is a psychologist at Fairview Behavioral Services and author of "Selling Out America's Children," published by Fairview Press.

I would like to learn more about what
MMBR Motor Services can do for me
on the lease/purchase of my next vehicle.

Name _____

Address _____

City _____ State _____ Zip _____

Please contact me at my ☐ Home ☐ Office

Phone number _____

I plan to ☐ lease ☐ purchase a new vehicle

Within ☐ 3 months ☐ 6 months ☐ 12 months

MN/MED



NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761

**An auto lease/purchase
company solely dedicated
to serving physicians.**

MMBR Motor Services



**Here's what
MMBR Motor Services
is committed to doing
for you:**

When you call us, we go to work providing free consultation to help you outline your vehicle needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle. Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease we will arrange to have your vehicle professionally detailed, assuring high resale value by helping keep your vehicle in top condition.

We provide complete support after the lease/purchase. If you have a question, call us.

For *personal attention* on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 1/800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.



MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*



Pierre duCharme
Perham



Rick Sall
Duluth



Rich Westlund
Hutchinson



Don Anderson
St. Cloud



Dave Westlund
Hutchinson



Joe Steck
Mankato



Scott Weilage
Mankato



Jim Erickson
Rochester

*Quality...Service...
Convenience...
from people you
can trust.*

Minnesota Physicians Insurance Agency is a statewide network of counselors uniquely dedicated to personally managing risk for physicians, their families, their clinic, and their employees. You can count on us to deliver the highest quality insurance products at the best possible price, negotiated specifically for you. We combine expertise with a level of service and convenience health care professionals like you have the right to expect.

Call us at 612/623-2860 or toll free 800/298-MMBI and we'll send you an overview of available products.

**MINNESOTA PHYSICIANS
INSURANCE AGENCY**

A MMBR Company

*Owned by the members
of MMA and HCMS.*



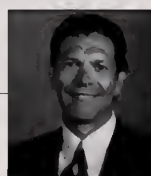
Angela Erickson
Hastings



Debra Newman
Edina



Dick Mussell
Anoka



Mike Prazich, D.D.S.
Plymouth



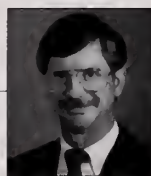
Brian Mikkelsen
Minneapolis



Wil Heupel
Minneapolis



Mark Bryant
Wayzata



Bob Anderson
Hopkins

People and Places Making Medical News

People

President Clinton Honors St. Paul Woman

Bonnie Clairmont of St. Paul was honored in April by President Clinton for her 14 years of outstanding service as a volunteer advocate and counselor for battered women and sexual assault victims in the American Indian community. She was among 10 Americans who received awards at the White House Ceremony for serving as "lifelines" for victims of violent crimes.

Clairmont is one of the first Native American women in the country to organize and provide culturally appropriate education and services to victims of violence in the Native American community, according to a White House statement.

As a counselor at Sexual Offense Services of Ramsey County, Clairmont provides counseling, crisis intervention, and advocacy for women and children who have been battered or sexually assaulted. She also gives presentations in Ramsey County schools on how to prevent sexual violence.

Fairview Promotes Senior Executives

Fairview Health System recently promoted two top executives: **Jim Fox**, now senior vice president and chief financial officer, and **Bonnie Marsh**, now senior vice president of strategic development.

The retirement of two top officials, Donald Ramsey, former chief financial officer, and Douglas Robinson, a senior vice president, prompted a senior-level staff reorganization that began last year. Although Fox and Marsh will assume some of the responsibilities of the two retired officials, they are not replacing them.

Fox has worked at Fairview for

the past 20 years. He was previously responsible for legal matters and health plan relationships. Before joining Fairview in 1993, Marsh was vice president of Minneapolis Children's Medical Center.

HealthEast Hires New Director

Kathleen Lucas is the new director of HealthEast Hospice and HealthEast Optional Care services, two in-home health care programs.

Before joining HealthEast, Lucas was employed by In Home Health, Inc. as corporate vice president of Certification and Compliance, and before that, director of Fairview Home Care and Hospice.

HealthEast Hospice provides both hospital-based and home-based care for terminally ill patients. HealthEast Optional Care provides services to patients, including babies, who receive health care at home. Together, the services have 193 staff members and about 350 field staff.

HCMC Administrator Receives Award

John W. Bluford, administrator of Hennepin County Medical Center, received the Alumni of the Year Award from Northwestern University's J.L. Kellogg Graduate School of Management's Black Management Association.

The award, which recognizes excellence in career accomplishment and community service, was presented to Bluford in April at the association's Eighth annual African-American Business Conference on the Northwestern campus in Evanston, Illinois.

Bluford has been administrator of HCMC since 1993 and has held other HCMC administrative posts since 1984. He is also the founder and executive director of Metropolitan Health Plan, one of the

country's first health maintenance organizations for the public sector.

HCMC Medical Director Re-elected

Michael Belzer, M.D., medical director of Hennepin County Medical Center, was re-elected by the Hennepin County Board of Commissioners to a second five-year term.

"Dr. Belzer was successful during his first term in providing leadership in a number of areas regarded as critical to the continued viability of HCMC as a strong community resource," said HCMC Administrator John W. Bluford.

Belzer, an oncologist, joined the HCMC internal medicine department in 1980.

St. Paul-Ramsey Physicians Honored

Five staff physicians at St. Paul-Ramsey Medical Center received special recognition awards in April at the medical staff's recognition dinner held at the Radisson Hotel in St. Paul. **Paul Abraham, M.D.**, chief of nephrology, received the Robert O. Mulhausen Award for Teaching Excellence. **Diane Madlon-Kay, M.D.**, research coordinator for the family and community medicine department, received the Ramsey Young Investigator Award for enriching clinical practice by conducting and teaching medical research early in her career.

The Ramsey Special Recognition Award for outstanding contributions to the medical center was presented to three physicians: **Caroline A. Mason, M.D.**, chief of professional services at Suburban Square and Inver Grove Heights Group Health clinics; **David J. Mersy, M.D.**, chair of the family and community medicine department at St. Paul-Ramsey Medical Center; and **John W. Wheeler, M.D.**, internal medicine practitioner at the St. Paul Group Health

Clinic and member of the St. Paul-Ramsey Medical Center Board of Directors.

'U' Hires Chief Information Officer

The University of Minnesota Health System recently hired Michael N. Minear as chief information officer responsible for information management and development, including automating the health system's clinical knowledge base and leading the community health information networks.

Prior to his university appointment, Minear was a vice president at Medicus Systems Corp., a software and consulting company with more than 1,300 hospital clients nationwide.

P l a c e s

.....

Red Cross Opens State-of-the-Art Lab

The American Red Cross in May opened a state-of-the-art blood testing laboratory in Eagan. The lab is one of nine built since 1991 to help ensure the safety of the nation's blood supply.

The Eagan lab is equipped to test blood samples for a number of diseases, including AIDS, hepatitis, and syphilis. Operating 24 hours a day with the help of about 80 full-time employees, the lab will perform nine tests on about 600,000 blood samples collected annually from regional blood centers in St. Paul; Omaha, Nebraska; and Madison, Wisconsin. All tests will be completed within 17 hours after the samples leave the blood collection centers, and the results will be transmitted via computer. All failed samples are withdrawn immediately and the results sent to the Red Cross's main laboratory in Washington, D.C., to be rechecked.

The network of nine blood centers replaces 53 testing labs and is part of an overhaul of the nation's blood collection and testing system. The new centers will allow for standardization of procedures and better control.

Park Nicollet Expands, Renames Clinic

Park Nicollet Medical Center completed an expansion of its St. Louis Park campus in late April and at the same time assumed a new name—Park Nicollet Clinic HealthSystem Minnesota.

The expansion, which nearly doubles the size of the St. Louis Park clinic, includes 105,000 square feet of additional clinical space to accommodate predicted growth in the number of patients the clinic will serve. Additions include a two-story primary care medical building, a four-story medical building for surgical services, and a 675-car parking ramp, all connected by a skyway system.

The clinic's new name recognizes that the clinic is part of the integrated HealthSystem Minnesota, which also includes Methodist Hospital, Primary Physician Network, and the HealthSystem Minnesota Foundation.

S o c i o e c o n o m i c s

.....

HealthPartners Trying to Reduce Injuries and Violence

HealthPartners has set a goal to reduce serious childhood injury among its 650,000 members. Specifically, it aims to reduce childhood injuries requiring medical attention by 25 percent and injuries requiring hospitalization by 10 percent over the next four years. To do so, it will make protective equipment, such as bicycle helmets and gun locks, available at an affordable price. In 1994, HealthPartners members between ages 1 and 15 made more than 35,000 clinic visits for injuries.

HealthPartners is also developing a plan to reduce domestic violence among its members. The HMO is waiting to set specific goals until it has determined how prevalent domestic abuse is among its members. In the meantime, it will teach its providers to recognize

victims of domestic abuse and to intervene. The HMO will link victims and their batterers to programs in the community.

In Home Health Forming Partnership With National Company

Minnetonka-based In Home Health Inc. announced plans in May to form a partnership with Manor Care Inc. of Silver Springs, Maryland. The agreement, expected to be complete in late July or early August pending regulatory and shareholder approval, calls for Manor Care to purchase 40 percent of In Home's outstanding shares for \$21.8 million and invest another \$20 million in the company in exchange for convertible preferred stock.

Manor Care operates almost 180 nursing homes in 28 states, which will provide a large referral base for In Home's hospice and home health care services. Health care operations make up about 80 percent of the company's \$1.2 billion in revenues and 78 percent of its 1994 profits of \$78 million.

L a w & P o l i c y

.....

Policyholders Suing MedCenters

A number of accident victims insured through MedCenters Health Plan are suing the company for allegedly billing them the retail value of medical care when the health plan actually paid a lower discounted price to providers, defrauding the victims of a portion of their accident settlement. The question is who should benefit from the discounts negotiated with providers when patients must reimburse the insurer for care out of a monetary settlement they receive from a third party. The suit, which seeks class-action status for all such victims, alleges that the difference between the retail price and the discount price should remain with the policyholder, not MedCenters. The suit claims that MedCenters fraudulently billed at least 14 members.

Wisconsin Lab Charged With Reckless Homicide

The laboratory Chem-Bio Corp. of suburban Oak Creek, Wisconsin, was charged with two counts of reckless homicide in April for allegedly misreading the Pap smears of two women who later died of cervical cancer. Under a deal with prosecutors, charges were dropped against a technician and the doctor who supervised the lab.

One of the women who died, Karin Smith, 29, asked District Attorney E. Michael McCann to investigate shortly before she died of cervical cancer March 8. "It was her wish for someone to pursue this because she felt it went beyond negligence," said Smith's father, Jorgen Knudsen, in an Associated Press article. Her family settled a lawsuit against Smith's HMO, Family Health Plan, for \$6.3 million. The family of the other woman, Dolores Geary, who died in 1993 at age 40, settled for \$3.5 million.

McCann said the inquest jury of six laymen was the first in Wisconsin to consider criminal charges for a fatal misdiagnosis. If convicted, the company faces up to \$20,000 in fines. The supervising physician, Robert Lipo, is barred from acting as medical director of any lab and from supervising technicians doing tissue testing. Technician June Fricano agreed to work on salary or on an hourly basis instead of being paid by the number of samples analyzed. McCann said she examined 20,000 to 40,000 Pap smears a year, compared with the maximum of 12,000 recommended under professional standards.

The laboratory's lawyer, Martin Kohler, said the lab will fight the charges. "We believe it was an act of negligence and not criminal recklessness," he said.

Innovations

AAP Endorses Chickenpox Vaccine

The American Academy of Pediatrics has endorsed the new chickenpox vaccine, Varivax, produced by

Merck and Co. It recommends that one dose of the vaccine be given to all children between the ages of 12 months and 18 months and one dose to all children under age 13 who have not had the disease. The AAP recommends two doses of the

vaccine, given four to eight weeks apart, for children older than 13 who have never been immunized and have no history of chickenpox. It does not recommend the vaccine for children with immune system problems, including leukemia,

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

612-885-6224

1-800-842-6469



LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

lymphoma, and HIV, or children taking high doses of steroids. Pregnant teens should not take the vaccine because its effect on fetuses is unknown.

Chickenpox infects about 3.9 million people annually in the United States, about 9,000 of whom end up in the hospital. Complications from the viral disease lead to the deaths of about 100 people each year.

Medical Research

Military Women Often Abused, Sexually Harassed

Women in the military are frequent victims of domestic violence and sexual harassment, which may be responsible for an increased risk of depression, anxiety, and hospitalization, according to a Minnesota study reported in the American Medical Association's *Archives of Family Medicine*.

Maureen Murdoch, M.D., M.P.H., and Kristin L. Nichol,

M.D., M.P.H., from the Minneapolis Veterans Affairs Medical Center and the University of Minnesota Medical School collected data via an anonymous questionnaire given to 191 women hospitalized between 1992 and 1993 at the Minneapolis VAMC and 411 randomly selected female outpatients. They received responses from 333 female veterans. They found that domestic violence and sexual harassment are common experiences for women in the military. Reported rates of attempted and completed sexual assaults were 20 times higher than for other government workers, and the overall prevalence rate of sexual harassment was considerably higher than in other populations.

Ninety percent of the respondents under age 50 reported being sexually harassed while in the military, and 24 percent said they had experienced domestic violence within the previous year. Among older respondents, 37 percent reported a history of sexual harassment while in the military, and 7 percent said they had experienced domestic violence within the previous year.

Among those who reported being sexually harassed on the job, 25 percent of the female veterans under the age of 50 said they had either been raped or experienced an attempted rape by a coworker or supervisor, as did 8 percent of the older respondents.

There are more than 1.2 million female veterans in the United States and 77,000 women on active duty.

Cellular Phones Can Interfere With Pacemakers

Cellular phones can speed up or slow down pacemakers when placed near the implanted devices, according to researchers at the Mayo Clinic in Rochester and Mount Sinai Medical Center in Miami. The researchers recommend that people with implanted pacemakers avoid placing cellular

phones near the pacemaker's pulse generator.

The older analog cellular phones "did not cause any significant problems in our tests," said David Hayes, M.D., director of pacemaker services at Mayo in a Minneapolis-based *Star Tribune* article.

Medtronic, Inc., advises pacemaker patients to keep pocket-sized, fold-up phones at least 6 inches from the pacemaker or defibrillator and to hold the phone on the opposite side of the body from the implant's location. It suggests that patients do not carry the phone in a pocket or on a belt next to the implant and recommends that portable, more powerful phones be kept at least 12 inches from the pacemaker.

Mayo Studying Chest Pain

The Mayo Clinic in Rochester is conducting a study on how to better diagnose whether chest pain indicates a heart attack. Of the 750,000 Americans who go to hospital emergency departments each year with chest pain, 60 percent are classified as "intermediate," meaning their diagnosis is uncertain. Previous studies show that only about half of these patients' pain is related to the heart, but all are admitted to the hospital for 24 to 48 hours for observation, costing the health care system millions of dollars. The three-year, \$2.5 million study will focus on these intermediate patients to determine which patients are at high risk for heart attack and should remain in the hospital and which should be sent home and told to see their doctor.

Urban Children More Likely to Have High Blood Lead Levels

Children living in Minneapolis or St. Paul, where a Minnesota census tract shows that more than 20 percent of residents live in poverty, are more likely than other metro-area children to have elevated levels of lead in their blood, according to a survey conducted by

the Group Health Foundation under contract with the Minnesota Department of Health. Almost 12 percent of the children in the study had blood lead levels warranting concern. The lowest level at which health officials recommend action to prevent possible lead poisoning is 10 µg/dL. Just over 3 percent of the children tested had blood lead levels of 15 µg/dL or more.

Group Health researchers examined the blood test results for more than 9,600 children, ranging in age from 6 months to 6 years, who had been tested for lead between September 1992 and August 1993 at one of 17 health care organizations and social service agencies in the seven-county metro area.

High-poverty neighborhoods, as defined by the census tract, accounted for 68 percent of the children with blood lead levels above 15 µg/dL, and Minneapolis and St. Paul also accounted for an above-average share of the elevated blood lead readings in the survey.

African-American and Native American children in the survey were found to be at increased risk, but this was most likely because they tended to live in "high-poverty" census tracts. Children were also at increased risk if they lived in housing built before 1950, had recent changes in their place of residence, had a history of lead poisoning, or had a brother or sister with a history of lead poisoning.

Apolipoprotein E4 May Predict Chance of Alzheimer's

A blood test for apolipoprotein E4 predicted which patients with memory loss were most likely to develop Alzheimer's disease in a Mayo Clinic study reported in the April 26 *Journal of the American Medical Association*. The test can't predict conclusively who will develop Alzheimer's, but apo E4 is a strong risk factor for the disease.

The study included 66 patients who mentioned memory problems when seeing doctors at Mayo. Blood tests showed that 28 tested

positive for apo E4, and 34 tested negative. Seventeen of the 28 with apo E4 developed Alzheimer's within 4.5 years. Only eight of the 34 without apo E4 developed Alzheimer's in the same period. The blood test wasn't done on four of the 66 patients.

Researchers at Duke University first made the connection between the apo E4 protein and Alzheimer's in 1993. The Mayo Clinic study is the first to use the protein to predict whether patients with memory loss will develop Alzheimer's, said Ronald Petersen, M.D., a Mayo

Assistant Clinical Coordinator

The Foundation for Health Care Evaluation is seeking a physician for the position of Assistant Clinical Coordinator to work as part of a team in our statewide Health Care Quality Improvement Program. We are seeking one full-time or two part-time physicians. The position provides clinical leadership for conducting pattern analysis of care and outcomes for the Minnesota Medicare population, and implementing quality improvement and education programs with hospitals and physicians throughout the state.

Successful candidates will be board certified, with recent clinical experience, and experience with quality improvement in a hospital setting or applied research design. A master's in Public Health or Epidemiology or equivalent will be an asset. Successful candidates will demonstrate skills in education and communication within the health care community, plus the ability to be a "team player" in a multidisciplinary work environment.

Technical skills should include some or all of the following:

- The ability to understand concepts of statistical analyses and to communicate these concepts clearly to hospital and managed care administrative and medical staffs in order to change practice and outcomes.
- Experience in the analysis of clinical practice and outcomes data.
- Familiarity with and commitment to continuous quality improvement techniques.
- Familiarity with the principles of epidemiology.
- Experience in making presentations to physicians.
- A broad range of knowledge of current clinical research and practice guidelines.

Applicants should submit a detailed résumé to:

Catherine Corbett
Director, Human Resources
Foundation for Health Care Evaluation
2901 Metro Drive, Suite 400
Bloomington, MN 55425

*FHCE has a smoke-free environment
and is an Equal Opportunity Employer.*

Clinic neurologist and principal author of the study. He said the study's results will be used to help determine why people with the protein are more likely to develop Alzheimer's and to help researchers work on a treatment.

Study Shows Plunger Device No Better Than CPR

A California study shows that a modified toilet plunger used to revive heart attack patients works no better than cardiopulmonary resuscitation, according to a report in the April 26 *Journal of the American Medical Association*. The "CardioPump" was codeveloped by Minnesota researcher Keith Lurie, M.D., after a family in California had revived a man in cardiac arrest with a toilet plunger.

The study's results contradict a St. Paul study reported a year ago in *JAMA*, which showed that the pump vastly improved the chances that patients in cardiac arrest would arrive at the hospital alive.

In the California study, more than 400 heart attack patients in Fresno and San Francisco were randomly assigned to be resuscitated by the CardioPump or CPR. Of those treated with the pump, 16 percent of those in Fresno and 13.5 percent of those in San Francisco arrived at hospitals alive; with CPR, 20 percent of patients in Fresno and 14.5 percent in San Francisco arrived alive.

In the St. Paul study, 59 percent of those treated with the pump and 33 percent of those given CPR arrived at St. Paul-Ramsey Medical Center alive.

Lurie questioned the results of the California study, stating that emergency crews in California were never taught how to use the device properly. In addition, the emergency teams in California took longer on average to arrive at the hospital than the St. Paul paramedics. Lurie commented in a Minneapolis-based *Star Tribune* article that the device may not work everywhere and that success may depend on the efficiency of paramedics.

MM

"I never forget what it means to be a doctor, and what it means is embodied in the American Medical Association Principles of Medical Ethics."

Dr. Aliza Lifshitz - Los Angeles, California

Bringing medical care to illegal aliens and the underprivileged in Southern California. That's how Dr. Lifshitz acts upon her belief in the American Medical Association Principles of Medical Ethics, the cornerstone of our profession.

You are invited to join with Dr. Lifshitz in her efforts to bring quality health care to those in need. You are invited to join the American Medical Association.

Members of the AMA are encouraged to join their state, county, and specialty societies.

American Medical Association

Physicians dedicated to the health of America



**Hands
are not
for hitting.**

Domestic violence is preventable.

If someone is hurting you, call: 612/646-0994



Created by the Minnesota Coalition for Battered Women - 612/646-6177 V/TDD.

MMA

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

J U N E 1 9 9 5

June 14-16 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

June 16 **Fifth Annual Family Practice Conference** Duluth Clinic; Fitger's Theatre of the North, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

June 20-24 **Mayo Internal Medicine Eurodate 1995** Mayo Foundation/Vienna Medical Association; Vienna, Austria. CONTACT: Kay Kenitz, Mayo Foundation, Section of International Education, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

June 26-28 **Advances in Breast and Cancer Surgery** University of Minnesota Continuing Medical Education; University of Minnesota, Minneapolis, MN. CONTACT: Becky Noren, University of Minnesota, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

J U L Y 1 9 9 5

July 22 **Anatomy and Arthroscopy** American Association of Clinical Anatomists and the Mayo Foundation; Mayo Medical Center, Rochester, MN. CONTACT: Barbara Porter, Mayo Foundation, Continuing Medical Education, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-0026.

A U G U S T 1 9 9 5

Aug. 18-19 **Advanced Life Support in Obstetrics** Hennepin County Medical Center/Hennepin Faculty Associates; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

Aug. 27-30 **Minneapolis Transplant Congress: New Immunosuppressive Drugs** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing

Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

S E P T E M B E R 1 9 9 5

Sept. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Mental Health Issues for Primary Care Physicians** Allina Health System; Hotel Sofitel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12 **Molecular Biology for Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 14-17 **Mechanical Ventilation: Principles and Applications** University of Minnesota Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

S E P T E M B E R 1 9 9 5

Sept. 22-23 **The Child With Unusual Infections** University of Minnesota Continuing Medical Education; Park Inn, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

O C T O B E R 1 9 9 5

Oct. 7 **Surgical Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 16 **Endorectal Ultrasonography** University of Minnesota Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 22-23 **Nursing Home Medical Directors** University of Minnesota Continuing Medical Education; Sheraton Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 28-30 **Animal Models of Cardiac Dysfunction** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 29-30 **Recent Developments in Epilepsy and Neurology** Allina Health System and Minnesota Epilepsy Group; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

OCTOBER 1995

Oct. 5-7 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 6-7 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 6-7 **Front Line Neurology** Allina Health System; Marquette Hotel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 7 **Orthopedic Symposium** Allina Health System; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-15 **Radiology '95: General Radiology Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis MN 55414; 612/626-7600.

Oct. 13 **Insights and Outlooks** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 13 **Ophthalmic Plastics Course** Phillips Eye Institute and Allina Health System; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14 **Current Trends in Ophthalmology** Phillips Eye Institute and Allina Health System; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 18-20 **Internal Medicine Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 22-23 **International Symposium on Innovative Therapies (ISIT): Lysosomal Storage Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600.

Oct. 26-27 **Annual Fall Seminar—Obstetrics and Gynecology** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 26-27 **Trauma Management for Primary Care Providers** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Monroe is sitting pretty



Ranked 23rd in *100 Best Small Towns in America*, Monroe, Wisconsin, boasts a strong economy, year-round outdoor activities, a comprehensive and diverse school system, and many amenities for an excellent quality of life. Madison, WI, Dubuque, IA, and Rockford, IL, are just an hour away, while Chicago and Milwaukee are within an easy two-hour drive. When you're thinking about a setting for your professional practice and the "good life" for your family, give some thought to Monroe.

Our town of 10,000 is home to The Monroe Clinic, the hub of healthcare in Monroe. A consolidated and integrated healthcare facility including a 140-bed acute care hospital with 24-hour ER coverage and an adjoining 114,000 sq. ft. state-of-the-art clinic, The Monroe Clinic provides a full range of diagnostic and therapeutic testing and treatment. We invite your participation in our 50+ physician multispecialty group practice as a BC/BE physician in: FAMILY PRACTICE, OUTPATIENT PSYCHIATRY, ORTHOPEDIC SURGERY, DERMATOLOGY, AND EMERGENCY MEDICINE.

We offer productivity based pay with excellent 1st year income guarantee, freedom from office management and buy-in costs, and comprehensive benefits including \$3750 CME allowance. For more information, write or call: Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. 800-373-2564. Or fax resume to: 608/328-8269. EOE.



The Monroe Clinic
A proud caring tradition

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., June 15 for August ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Owatonna Clinic, P.A., is seeking BC/BE physicians in the following specialties: internal medicine, ophthalmology, and ob/gyn. The Owatonna Clinic, P.A., is a 24-physician, multispecialty practice located just south of the Twin Cities

on Interstate 35. Owatonna's population is 20,000 with a trade-area population of 69,700. Clinic offers competitive first-year salary guarantee, partnership at the end of one year with minimal buy-in, and a very competitive fringe benefits package. Respond with a CV or telephone call to Philip F. Wichmann, M.D., or David Berg, Administrator, Owatonna Clinic, P.A., 134 Southview, Owatonna, MN 55060; 507/455-4441. (1/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)



- Family Practice ● Internal Medicine
- Occupational Medicine
- BC/BE Specialists

FAMILY PRACTICE: Join Group or do Locum Tenens Join 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Seven-member Department has busy hospital and clinic practice.

OCCUPATIONAL MEDICINE: Five B.C. physicians looking for additional physician to join busy Occupational Health Department.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Kay Duffney
(612) 586-5876



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612•763•5123

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

OUR HIGH GROWTH LOCALE Means Expanding Opportunity

Comprehensive Medical Care is a progressive multi-specialty clinic located in a rapidly growing Northwestern suburb of Minneapolis. We currently have the following openings:

FAMILY PRACTICE

Our 23-member department requires an additional BC/BE family practitioner. You will enjoy an average four day work weekend and on-call duty every 21-23 days.

INTERNAL MEDICINE

The BE/BC Internist we are seeking will join a 3-person department. Interest in both in-patient and out-patient medicine is essential; subspecialty interest is an advantage.

We offer highly competitive salaries with production-based compensation, and exceptional benefits that include paid insurance and continuing medical education. Just 20 minutes north of downtown Minneapolis, our location features comfortable suburban living as well as easy access to a wide variety of cultural, educational, and recreational opportunities. To express interest, please send your curriculum vitae to:

John Bordwell, M.D.
Medical Director
COMPREHENSIVE MEDICAL CARE
9055 Springbrook Drive
Coon Rapids, MN 55433
(612) 780-7035

Equal Opportunity Employer

Family Physician to join the medical staff of five family practitioners in a well-established growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Work in two newly constructed, modern clinics and one is attached to the hospital. Excellent diverse patient population. Guaranteed salary with incentive plan and a broad range of benefits. Excellent. Call collect, 612/532-3154, or write to Frederick W. Haack, Administrator/CEO, Mille Lacs Health System, PO Box A, Onamia, MN, 56359. *6-9/95

Issues in Primary Care Conference: Friday, September 15 to Saturday, September 16, 1995, Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. *2-7/95

Internal Medicine—Minneapolis: BC/BE general internists needed to join the Department of General Internal Medicine of a 385-physician multispecialty clinic in desirable Twin Cities area. Currently, we have two positions available at our Burnsville office. These are traditional practices with both ambulatory and hospital components. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at 612/932-5986, or send CV and letters of inquiry to Professional Practice Resources, Park Nicollet Clinic HealthSystem Minnesota, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; or fax: 612/932-6490. 2-7/95

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine	OB/GYN
Internal Medicine	Neurology
Orthopedic Surgery	Pediatrics
Noninvasive Cardiology	Urology

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-4592.

Moonlight Home Care, Inc.

1007 East Franklin

Minneapolis, MN 55404

612/870-7886

(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Family Practitioner • Internist

BOTH Want the best of worlds?

Live and work in a rural community—yet have easy access to the educational, cultural, shopping, and entertainment opportunities of the big city. Enjoy all the benefits that go with small-town living—good neighbors, safe schools, affordable housing, abundant recreational choices—and go to the city when you want!

St. Croix Falls, Wisconsin is located just over the scenic St. Croix River from Taylors Falls, Minnesota and within 45 minutes of the metropolitan Twin Cities. With 25,000 households within the clinic service area, River Valley Medical Center is the region's largest and most diversified practice group—13 family practitioners, 2 internists, 2 general surgeons, 2 orthopedic surgeons and a physician assistant. Clinic is attached to a 50-bed acute care hospital with a wide range of services.

Guaranteed first-year salary with second-year partnership and excellent fringes.



Send detailed CV to:
Cathy Kortas
River Valley Medical Center
208 S. Adams St.
St. Croix Falls, WI 54024



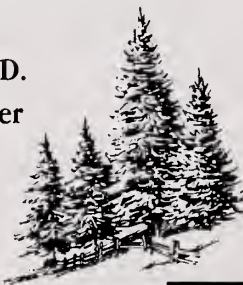
Emergency Medicine Physician

Minnesota, Brainerd:

Opportunities for 2 BC/BP primary care or E.M. physicians to work in growing medical community; most secondary and some tertiary capabilities with good primary care base and core group of quality E.D. physicians. Moderate volume (18,000 visits per year) 162 bed rural referral center – good EMS. Quality lifestyle with excellent schools, friendly people and very good housing values in “God’s country” – clean air, lakes, pines and an abundance of recreational opportunities – two hour drive to Minneapolis - St. Paul. Competitive compensation and benefits. Director position available for qualified/experienced candidate.

Send CV or call:

Nicholas Bernier, M.D.
St. Joseph’s Medical Center
523 North 3rd Street
Brainerd, MN 56401
(218) 828-7657



Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. 3-6/95

Family Practice—North St. Paul, Minnesota: Family practice group of four seeks to fill vacancy. Full range of family practice with ob/pediatrics/geriatrics. Stable community clinic since 1946 with excellent growing patient population. Hospital affiliation is St. John’s Northeast and Health-East facilities. Opportunity for one-year salaried position with subsequent by-in to partnership. Clinic is associated with East Metro Health Organization with multiple insurance contracts. Contact Marty Dennison, M.D., 2579 East Seventh Avenue, North St. Paul, MN 55109; 612/777-7414. *3-6/95

Lecture Series for Single Professionals Ages 35 to 50: We are planning a series of “mini-lectures” on serious and not-so-serious topics. Each session will include hors-d’oeuvres and an opportunity to meet single women and men in a comfortable setting. For more information call 612/897-6815. *1-6/95

•••EMERGENCY MEDICINE POSITIONS•••

Northern and Central Minnesota

Emergency Medicine opportunities are available now. Full-time and part-time staff positions in moderate volume emergency departments. Attractive, comprehensive benefit packages with paid malpractice. Beautiful surroundings, numerous recreational activities, excellent schools in economically stable, safe, family-oriented communities. Practice medicine in friendly professional environments at a pace that allows ample time for family and leisure activities. Call today for more information.

Iowa

Opportunities for prosperous lifestyles in several friendly Iowa communities. Secure practices with progressive physician-owned group. Excellent compensation packages, pleasant working conditions with appreciative patients. Various locations, reasonable housing in safe communities with top-notch school systems and Midwest values. Life in Iowa is measured by its warm, friendly people and quality lifestyles. Come join us.

- Call 1-800-458-5003 or send CV to Sheila Jorgensen, P.O. Box 1260, Waterloo, IA 50704

•••••

WISCONSIN MINNESOTA MICHIGAN
ILLINOIS IOWA NEW YORK

Great Lakes Great Life

Strelcheck and Associates, a respected search firm, invites you to consider a wide variety of group practice opportunities in the *Great Lakes Region*. Whether you prefer a metropolitan/suburban city, scenic college town, restful resort community, or something in-between, we have the setting for you! Many prominent groups and hospitals have come to rely on our professional approach to physician staffing. Call us toll-free at 800-243-4353 so we can earn your trust as well.



Strelcheck and Associates, Inc.
10624 N. Port Washington Road
Mequon, WI 53092

FAMILY PRACTICE INTERNAL MEDICINE PEDIATRICS
NEUROSURGERY NEPHROLOGY

No Assembly Lines Here: FPs, IMs, and ob/gyns at North Memorial-owned and -affiliated clinics don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of our 25 practices in urban and semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs call 800/275-4790, or fax CV to 612/520-1564. 1-6/95

St. Paul, Minnesota: BC/BE family physician to join a small suburban branch office of Ramsey Clinic—a 215-physician multispecialty group with affiliations with HealthPartners and St. Paul-Ramsey Medical Center—a regional tertiary care facility. The Maplewood office is a six-physician primary care clinic located in Maplewood, Minnesota, just 10 minutes from downtown St. Paul. At Ramsey Clinic-Maplewood, you can enjoy the practice style of a smaller practice, yet benefit from the professional and administrative support of our large multispecialty group. Opportunities to practice obstetrics or engage in teaching and research are optional. Send CV or contact: Karen Steiner, M.D., or Nancy Swenson, Manager, c/o Ramsey Clinic-Maplewood, 1774 Cope Avenue, Maplewood, MN 55109; 612/770-1497. 4-8/95

Multi-Disciplined Rehab Facility in Metro Area, which specializes in the treatment of auto and work-related injuries, seeks physician with similar interests. Great opportunity to join an aggressive team in a unique practice. Contact Craig Seifert, 612/798-1020. 2-6/95

WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

Academic Hematologist/Medical Oncologist Department of Medicine Hennepin County Medical Center

Hennepin County Medical Center, a University of Minnesota-affiliated teaching hospital, is seeking an academically oriented board certified/board eligible Hematologist/Medical Oncologist. Candidates should demonstrate strong clinical abilities and display effective administrative and educational skills. Responsibilities include providing medical care and educating medical students, residents, and fellows. Experience in conducting clinical and outcome-based research is desirable.

Depending upon experience and qualifications, the candidate would be eligible for a full-time, renewable-term University academic appointment at the Assistant Professor level or above, with the approval of the Department of Medicine and the Promotions and Appointments Committee of the University of Minnesota Medical School.

The University of Minnesota and Hennepin Faculty Associates are equal opportunity educators and employers who specifically invite and encourage applications from women and minorities.

Interested candidates should contact Dr. Tanya Repka on or before June 30, 1995.

Tanya Repka, M.D., Interim Director
Hematology/Medical Oncology Division
Department of Medicine
Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55415
612-347-8724

Would you enjoy being nestled between Lake Superior and the BWCA?

This could be the next phase of your career!

If you love your practice, but are excited by new challenges, consider joining the physician faculty at the Duluth Family Practice Residency. While the residents benefit from your knowledge of practice in the '90s, you will flourish in one of the most livable cities in the country.

*Would you enjoy a collegial practice with specialists of all types?
Have you dreamed of working where you like to play?*

Applicants must hold M.D./D.O. degree, be ABFP certified and have, or be eligible for, a Minnesota license. Practice experience with obstetrics is required. Teaching experience and knowledge of family practice in the managed care setting are desirable. Responsibilities include teaching residents, administrative/research, and patient care. The affiliated School of Medicine in Duluth provides opportunities to teach medical students.

*To apply, submit a letter of interest, a resumé,
and names of 3 references before July 15, 1995, to:*

ROGER K. WAAGE, M.D.
Chair, Faculty Search Committee
Duluth Family Practice Residency Program
330 North 8th Avenue East • Duluth, MN 55805
218/725-2601

*Applications received before the initial deadline of
May 15 are now being reviewed.*

*The Duluth Family Practice Residency Program
has an academic affiliation with the University of
Minnesota Duluth and is an equal opportunity
educator and employer.*



Internist or Family Physician: Board-certified internist or family physician with expertise in women's health wanted for staff positions for expanding Women's Health Center in St. Paul, Minnesota. The clinic's focus is primary care for women from adolescence through geriatrics. The Women's Health Center is associated with Ramsey Clinic and the St. Paul-Ramsey Medical Center, which are associated with the University of Minnesota Internal Medicine Residency program. Opportunities exist for full- or part-time positions. Please send CV and correspondence to Beth Averbeck, M.D., Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. EOE. *2-6/95

Internist: Board-certified internist with expertise in women's health care and administrative experience wanted to direct expanding Women's Health Center in St. Paul, Minnesota. The clinic is associated with Ramsey Clinic and the St. Paul-Ramsey Medical Center, which are associated with the University of Minnesota Internal Medicine Residency program. Candidates should also have experience in patient care, research, and education. Please send CV and correspondence to Beth Averbeck, M.D., Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. EOE. *2-6/95

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE, to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Josephe E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-8/95

Whitefish Lake Retreat with all amenities on best "chain of lakes" in Minnesota, just minutes from Brainerd. Five bedrooms, four baths in shared 300-acre preserve with tennis court. Includes use of canoe, 14-foot fishing boat, and sailboat. Excellent swimming. \$2,100 per week. 612/228-1104. *1-6/95

JUNE 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Army Reserve	27
Aspen Medical Group	3
Central Minnesota Group Health Plan	13
C.F. Anderson Co., Inc.	23
Chisago Health Services	23
Columbia Park Medical Group	60
Comprehensive Medical Care	60
Emergency Practice Associates	62
Fairview Clinic Services	53
Family Practice Residency Program	63
Fargo Clinic MeritCare	27
Foundation for Health Care Evaluation	46, 55
HealthEast	Cover 4
HealthPartners	4
Health Risk Management	26
Hennepin Faculty Associates	63
Midwest Medical Insurance Co.	Cover 2
Minnesota Medical Business Resources	32, 41, 49
Minnesota Physicians Insurance Agency	Cover 3, 47, 50
MMA Peer Review Consultation Services	44
Monroe Clinic	58
Moonlight Home Health Care	61
Multicare Associates of the Twin Cities	31
Norwest Center	26
Oxboro Clinics	63
River Valley Medical Center	61
Sletto & Associates, P.A.	48
St. Francis, Inc.	61
St. Joseph's Medical Center	4, 62
Strelcheck & Associates, Inc.	62
Thunderbird Aviation, Inc.	23
Veterans Administration Medical Center	4
Webb Financial Group	3
Whitesell Medical Locums, Ltd.	54



DI Coverage: Going, Going...

Most physicians carry some sort of individual disability income insurance. From medical school on, doctors are approached time and again by agents and planners of all kinds, offering to review the coverage currently in force. The trend has always been one of better policy features and more and more aggressive marketing. In short, if one company wasn't willing to give the doctor the coverage he or she desired, there were literally dozens of other companies ready to fill the void.

End of an Era

But, those days are gone. In the last two months, the noncancellable individual disability insurance industry has seen the withdrawal of four of the major carriers, and other carriers have announced major changes to the types and costs of policies offered to physicians. Poor claims experience from these companies' 1985-1989 blocks of business, and especially poor claims experience with physicians in particular, has led these companies to take the actions stated above.

What Happened to DI?

In the simplest terms, overaggressive marketing and sloppy underwriting created a situation in which companies charged unrealistically low premiums and then had to pay more in claims than they had projected. Since the true financial performance of a disability product isn't known for several years, by

the time some of these DI underwriters realized what was happening, it was too late to take corrective action. Compounding the problem in the physician marketplace was the fact that large numbers of doctors were underwritten by these companies, and doctors made large numbers of claims over the past 18 months.

So Now What?

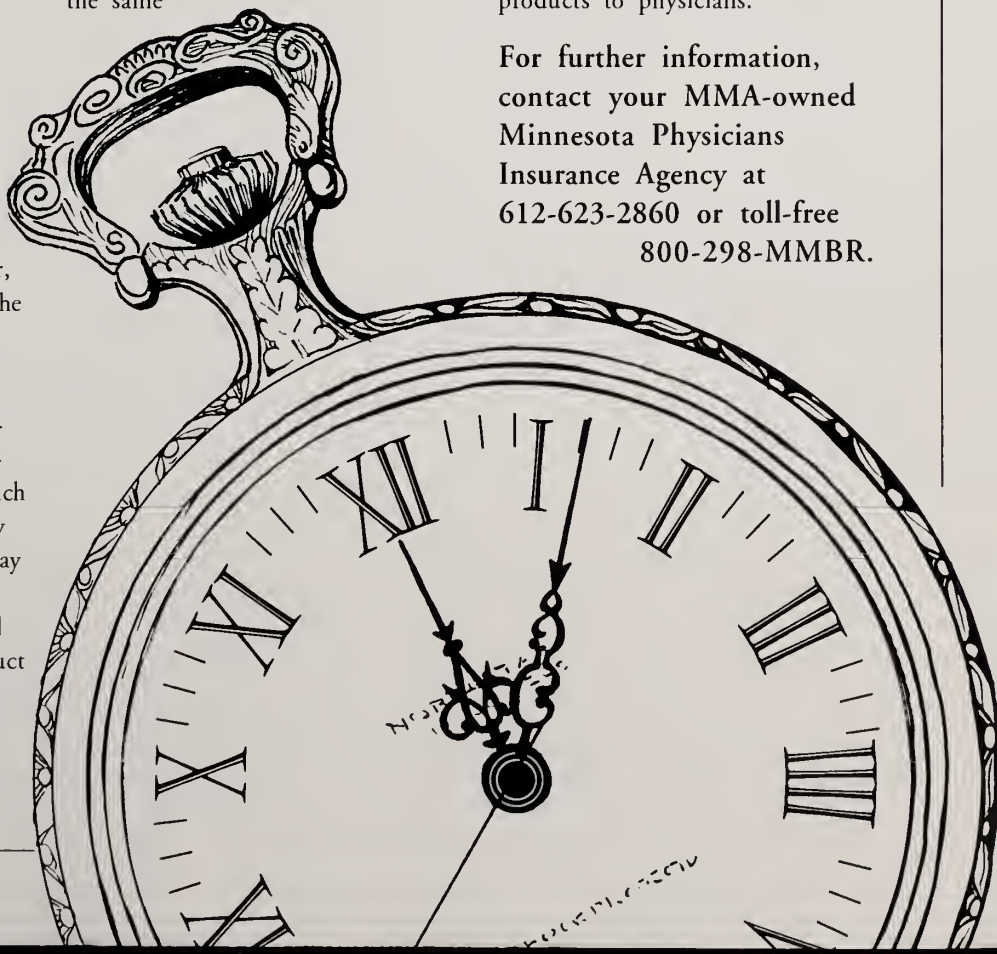
The net result is that physicians today are no longer preferred business by all carriers. And, what most doctors have now for individual disability income coverage is what they will have to stay with. There is, however, a very small window of time left for a review of that coverage, but within the next few months, the ability to purchase the same

quality DI contracts most physicians enjoy today will not be possible. Among the items that some carriers have scheduled for the chopping block are fixed premiums, "own occupation" protection, and voluntary rehabilitation benefits.

All Is Not Lost

Not all companies are pulling out of the individual disability income arena. Among the few who will remain is the MPIA-endorsed carrier, Paul Revere. As the nation's leading disability carrier, Paul Revere is better situated to weather the current storm. Although experiencing some of the same difficulties as other carriers, it has managed to remain profitable while offering competitive DI products to physicians.

For further information,
contact your MMA-owned
Minnesota Physicians
Insurance Agency at
612-623-2860 or toll-free
800-298-MMBR.



HealthEast Bethesda Lutheran Hospital & Rehabilitation Center



**OVER
10,000
PEOPLE
ALREADY
KNOW
OUR
SECRET.**

They know it first hand. They know the whole story, from the morning Larry Jones walked again to that day when Mary Butler's pain finally stopped. They know that Minnesota's premier rehabilitation center is just two blocks from the state capitol.

Most folks from the Twin Cities area have heard of HealthEast Bethesda Lutheran Hospital and Rehabilitation Center. It's been part of the community for over 112 years. But when Peter Ridley learned to talk again—and how to breathe without the aid of a ventilator—he wanted to tell everyone that this dedicated facility is one of the best kept secrets in town.

Scope of services: Geriatric Behavioral Care • General Medical Services • Wound Care
Ventilator/Respiratory Care • Neurobehavioral Services • Rehabilitation Inpatient Services
Pain Management • Swallowing Disorder Treatment • Transitional Short-Term Care

For more information

Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center
559 Capitol Boulevard St. Paul, MN 55103

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS



12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession
Pittsburgh, PA 15261-0001

*Allied Providers
Extend Medical Care*

Where knowledge and practice interact



CONTINUING MEDICAL EDUCATION

Continuing Education and Extension, University of Minnesota

Selected Courses, Summer-Fall, 1995

Advances and Controversies in Critical Care

July 7-8 • Minneapolis

Minneapolis Transplant Congress: New Immunosuppressive Drugs
August 27-30 • Minneapolis

Molecular Biology of Colon and Rectal Surgery
September 12 • Minneapolis

Principles of Colon and Rectal Surgery
September 13-15 • Minneapolis

Mechanical Ventilation: Principles and Applications
September 14-17 • St. Paul

Endorectal Ultrasonography

September 16 • St. Paul

The Child With Unusual Infections
September 22-23 • Minneapolis

Annual Meeting, Minnesota Nursing Home Medical Directors
September 22-23 • St. Paul

Animal Models of Cardiac Dysfunction
September 28-29 • Minneapolis

Lasers in Cutaneous & Cosmetic Surgery

September 29-Oct. 1 • Orlando

Medical Directors Training Program
October 5-7 • Minneapolis

Arthroscopic Microdiscectomy of the Lumbar Spine
October 6-7 • Minneapolis

Surgical Infectious Diseases
October 7 • Minneapolis

Radiology 95: General Review
October 11-15 • Minneapolis

Internal Medicine Review
October 18-20 • Minneapolis

Lysosomal Storage Diseases
October 22-23 • Minneapolis

Obstetrics and Gynecology: Annual Autumn Seminar
October 26-27 • Minneapolis

Cancer Center Program Head and Neck Cancer
November 3 • Minneapolis

JUL 17 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Nurse practitioner Mary Beth Hanson, Park Nicollet Clinic HealthSystem Minnesota, with patient Tony Rabiola. Photo by Richard Anderson.

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 22 AUTHOR INSTRUCTIONS
- 52 NEWS CLIPS
- 57 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

FACE TO FACE

- 6 FOSTERING COLLABORATIVE CARE** James Bohen
The work of nurse practitioner Jay Fotland exemplifies the NP-physician collaboration touted as a possible solution to the rural physician shortage.

PERSPECTIVES

- 8 BEATING THE ODDS** Stephen Rapatz-Harr, PA-C
Patients need encouragement when the numbers don't look good.

FEATURE STORY

- 10 A MEASURE OF INDEPENDENCE** Katie Colón
Nonphysician practitioners have become vital members of the health care team, but the scope of their practice is still under debate.

CLINICAL & HEALTH AFFAIRS

- 17 SHOULD A GERIATRIC NURSE PRACTITIONER BECOME PART OF A MULTISPECIALTY GROUP?** Barbara P. Yawn, M.D., M.S., and G. Richard Geier Jr., M.D.
- 23 LASERS IN UROLOGY** Eduardo T. Fernandes, M.D., Paul Gleich, M.D., and Cesar Ercole, M.D.

MEDICINE LAW & POLICY

- 29 PHYSICIAN EMPLOYMENT AGREEMENTS: WHAT TO LOOK FOR** .. James Platt, J.D.
Negotiating a fair contract with a new employer is crucial in this age of shifting health care affiliations. Here's what you should consider.

SPECIAL REPORT

- 41 EMERGING INFECTIOUS DISEASES: CONTROVERSIES, CAUSES, AND CONTROL** Kristine L. MacDonald, M.D., M.P.H., and Michael T. Osterholm, Ph.D., M.P.H.
The dangers of emerging pathogens are real, but they need to be placed in a broader medical and epidemiologic perspective.

BOOK REVIEW

- 45 SPREADING THE FEAR OF INFECTIOUS DISEASE** Charles R. Meyer, M.D.
"The Hot Zone" and "The Coming Plague" tell the intriguing tale of our battle with infectious disease, but are these books overly alarmist?

33 *The* Monitor

HIGHLIGHTS MMA launches campaign against media violence • Viewpoint: Medical Alley introduces guidelines to measure cost-effectiveness

**IN 1943, WE DISCOVERED
AN INTERESTING TREND:
MEN HAVING BABIES.**

Back before there were computers, hospital claim forms had to be checked by hand. So it took a keen pair of eyes to notice billing charges for male maternity services among the stacks of forms. As it turns out, it was a simple paperwork error that was easily corrected. Fifty years later, we're still committed to making health care as efficient as possible. Our electronic claims system now links virtually every provider in Minnesota and over 140 different health plans nationwide. Last year, this paperless system transmitted more than 13 million claims electronically. Not only are the cost savings enormous, it can actually impact the quality of care you receive. One hospital found its nurses spent 22 percent less time on paperwork and doubled the time spent with patients. This is just one of the many ways Blue Cross and Blue Shield of Minnesota is making real-life improvements in how health care is delivered. For our free guide to better health, call 1-800-922-3822, ext. 20 or 612-946-7400, ext. 20.





**BlueCross BlueShield
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical
Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.
Secretary
Thomas B. Dunkel, M.D.
Treasurer
Erick Reeber, M.D.
Speaker of the House
Barbara P. Yawn, M.D.
Vice Speaker of the House
Anthony C. Jaspers, M.D.
Past President
C. Randall Nelms Jr., M.D.
Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Charles S. Winjum, M.D.
N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.
N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.
West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.
East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.
S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.
S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.
Resident Member
Scott Stafford, M.D.
Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.
AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair
AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.
Director of Legislation and Public Policy
David Renner
Director of Communications
Mark S. Vukelich

Division of Labor

Charles R. Meyer, M.D.

Before the 1870s, trained nurses were virtually unknown in America. Hospital nursing was a menial occupation, taken up by women of the lower classes, some of whom were conscripted from the penitentiary or the almshouse.

—Paul Starr

"The Social Transformation of American Medicine"



"Nonphysician practitioners already play a vital role in medical care. Should they be granted more independence?"

Nurses have come a long way. Rising in the late 19th century from the abysmal conditions described above, nurses became indispensable, skilled providers of care to hospitalized patients through aggressive campaigning by aristocratic women battling physicians wedded to the status quo. Now, on a different scale and likely less vituperative, nurses and their descendants—nurse practitioners and physician assistants—are pushing for an expanded role in the delivery of medicine. These nonphysician practitioners (NPPs) already play a vital role in medical care, but concerns related to money and access are calling the question, should NPPs be granted more independence? July's *Minnesota Medicine* probes for answers.

This issue includes a summary of the current status of NPPs and proposals for wider responsibilities, a profile of a nurse practitioner at the Kenyon Mayo Family Practice Clinic in Rochester, Minnesota, and a survey of one medical group's experience with geriatric nurse practitioners. As described in these articles, NPPs in their present roles seem to be working. So where's the beef?

Confirmed skeptics will ask, "Why change?" Inveterate cynics will answer, "Money." Indeed, the incredible shrinking dollar has led health care gurus to search for cheap

er ways to treat more patients. NPPs' time costs less than physicians'. They widen the pool of practitioners available to work in underserved areas. Also, the efficient matching of complex problems with advanced training—"Leave the tough stuff to the docs"—is appealing to proponents of more NPP duties. Beyond purely financial considerations, the nurse leaders quoted in our cover story by Katie Colón argue that NPPs can provide more quality time for patients, concentrating more on education and prevention than their MD counterparts do.

So what do NPPs want to do that they aren't now doing? Independent practice, procedures, and prescribing. In some settings, NPPs do have a measure of autonomy. Jay Fotland's practice, described in this month's Face to Face profile, could best be described as independence with consultation available. Independent billing by NPPs is allowed in two states.

Numerous studies have documented nurse practitioners performing sigmoidoscopy and colonoscopy with polyp-finding accuracy and complication rates equal to physician-executed procedures. Twenty-two states allow some prescribing by NPPs. NPP proponents would like these experiences generalized and legalized.

So why not expand NPP roles? Turf protection is one reason. Certainly, primary care physicians are asking themselves, "If NPPs handle more primary care problems, and specialists carve off the congestive heart failure, diabetes, and COPD, what's left?" This is a financial *and* a quality-of-professional-life question. Power and pesos aside, many physicians would challenge the contention that they have ignored or are ignoring the "whole person."

However, the clincher question is, will it be good medicine? NPPs currently work in collaborative practices with physicians without any documented compromise in practice quality. But when NPPs don't have an MD nearby to check the rash, listen to the lungs, or hear the history, will they pick up the sore throat that is epiglottitis or the cough that is congestive heart failure? The main benefit of four years of medical school and years of residency is depth. Physicians are trained to look beyond the obvious and know the wealth of possibilities. That will always be valuable.

With safeguards, a larger role for NPPs can work. As physicians, we should avoid repeating the benighted obstructionism of our 19th-century forebears. If they had prevailed, we might have felons administering chemotherapy today. The best system will be one that uses the training of our professionals to deliver compassionate and competent care at a competitive cost.

MM

FOSTERING COLLABORATIVE CARE

The work of nurse practitioner Jay Fotland exemplifies the successful NP-physician collaboration touted as a possible solution to the physician shortage in rural Minnesota.

James Bohlen

Jay Fotland spends most of his time in the quiet southeastern Minnesota town of Kenyon, delivering care to about 25 patients a day. But he's also in the maelstrom of a national debate. Fotland is the Kenyon Mayo Family Practice Clinic's primary care provider, but he is not a physician. He is a nurse practitioner—a group of caregivers gratefully embraced by some physicians as a means to extend medical care to underserved populations, yet eyed with suspicion by others as usurpers of medicine's claim to primary care. Fotland's practice exemplifies the potential of a collaborative relationship between physicians and nurse practitioners to bring care to rural Minnesota.

Hired in late 1993 by Mayo Clinic to be the full-time primary caregiver at a pilot rural satellite clinic in Kenyon, Fotland isn't interested in running an independent clinic or being in the middle of the discussion between nurses and physicians about which group provides what primary care. Although he believes nurse practitioners can function independently, he prefers to concentrate on seeing patients.

Nurse practitioners and physicians are not in competition, says Fotland. They complement each other. "Nurse practitioners are trained to know what normal is. Medical doctors are trained more intensely to know what abnormal is. I'm a nurse, not a 'mini-doctor.' I like to focus my practice more on wellness than on disease. I like to talk about things that will improve people's health. Busy physicians often don't have the luxury to take the time with patients because it's not as cost-effective and doesn't properly utilize their training; nurse practitioners can take that time."

Nurse practitioners are registered nurses with more advanced training. They're licensed to perform physical examinations, diagnose and handle common medical problems and minor medical emergencies, and manage certain chronic conditions, such as diabetes. Their level of independence from physicians varies from state to state. In Minnesota, nurse practitioners must have collaborative agreements with physicians who list what they can prescribe.

Before joining the Kenyon clinic, Fotland was a nurse practitioner for more than eight years in Seattle, where he worked in a community health center, a walk-in clinic, and a multi-physician practice. At the walk-in clinic, he was on his own most of the time. He saw an average of 45 patients per day, handling five exam rooms, and sometimes suturing one patient while two more waited for stitches. He also prescribed drugs for many psychotic and depressed patients because there were no psychiatrists available to his mostly homeless, indigent patients.

"In Washington, nurse practitioners were more independent than



they are in Minnesota,” Fotland says. “They didn’t have to be associated with a doctor. Most physician practices in Seattle have nurse practitioners on staff because they add to the practice. Nurse practitioners have time to teach seminars and can take pressure off the walk-in load. Seattle medical doctors look at nurse practitioners as assets to their practice because we complement what they do,” he says.

Minnesota has been slower to give nurse practitioners that same level of independence. Although physician supervision of NPs is not mapped out in law, NPs must have a signed agreement with a physician outlining the NP’s prescribing privileges and authority to order lab tests, x-rays, and physical therapy. Nationally, NPs have been pushing for more independence; skeptical physicians question whether quality will suffer if NPs assume more responsibility for primary care—and worry that their lower cost will push primary care physicians out of business. At the AMA’s interim annual meeting in Hawaii this winter, delegates expressed alarm about nurse practitioners’ drive for independent practice, but they did endorse a plan to cooperate with nurses as part of an integrated

health care team. Many physicians consider nurse practitioners beneficial and cost-effective team members—freeing up time for physicians to concentrate on more technical matters and smoothing out their workload.

“I feel as independent as I was in Washington because the physicians I work with at Mayo are great,” Fotland explains. “They’re fully supportive because they know I’m well aware of my limits, that I know when I’m in over my head. They’re comfortable with my records and my level of care. And the more comfortable they are, the more responsibility I have.

“I feel I’m providing my patients the same level of care a physician would provide,” he adds. “I can handle about 90 percent of the cases that come through the door. I follow the same care guidelines as Mayo doctors and make the same diagnosis most of the time. I base how I treat patients on the severity of their illness and locate care if they need more than

FOTLAND continued on page 48

BEATING

I like being a physician assistant. I make no excuses for enjoying my job, at times to the distress of my spouse. Late days at the clinic can be habit-forming. My wife, Jenny, and I often joke about one of my father's familiar comments: "I can't wait for Monday to arrive so I can get back to work." Was my father nuts? Maybe, but so is his son. My enjoyment of my work is derived in part by the effect I have on others, but a larger measure can be attributed to the effect others have on me. I try to be a good listener and to understand patients' concerns. I strive to be honest and to provide as much

the **ODDS** By Stephen Rapatz-Harr, PA-C

information as patients wish to hear. Experience has taught me that such simple support can foster hope—and friendship—when patients face life-threatening illnesses.

vor. His anxiety appeared to be related to his wartime experience; he was convinced he was again facing death. Telling his story seemed to allay some of his fears.

While undergoing surgery the next day, Mr. Goldman experienced a near-fatal arrhythmia during the attempt to re-perfuse his myocardium. Fortunately, he responded to treatment and survived the surgery and hospitalization. I am sure high anxiety was a factor in the arrhythmia, as well as the patient's recovery. Mr. Goldman's survival instinct had pulled him through again, and, for the time being, God wasn't ready to take him home.

Several years later, the memory of Mr. Goldman was still clear, although I had set it aside for quieter moments of reflection. Then I met Sam Richards, who presented with similar problems, but of a much more acute nature. Mr. Richards, who like Mr. Goldman was middle-aged, arrived at the Walker Clinic on a warm summer morning, diaphoretic and holding his chest.

My role at the Walker Clinic was to see urgent care patients, which allowed the physician to concentrate on more complicated medical problems. I quickly made my assessment of Mr. Richards and called in the physician. The medical team, including nurses, the doctor, and I, quickly got him into a room and began administering to him while asking him questions about his pain and associated symptoms. We performed an ECG, started an IV, delivered oxy-

gen by pronged nasal cannula, and administered nitroglycerin under his tongue while the ambulance was summoned for a 30-minute ride to the Park Rapids hospital.

Mr. Richards didn't hide his thoughts and fears as we rode together in the back of the ambulance. "Am I going to die?" he asked. I was more concerned with monitoring his vital signs and pain levels than answering his questions. "Mr. Richards,

ODDS continued on page 50



ILLUSTRATION BY DAVID RICKERT

As a physician assistant student 18 years ago, I was called to the bedside of a patient preparing for coronary bypass surgery. The patient was distraught; fear blazed from his eyes. He pleaded, "Tell me, Steve, that the doctor is wrong, and that I'm not going to die from this procedure." Sure that Mr. Goldman had misinterpreted the doctor's comments, I described the procedure for him again, trying to balance the potential risks and benefits. As we talked, I learned that Mr. Goldman was a concentration camp survi-

On a typical day at the local health clinic in Clarissa, Minnesota, Mark Helgeson is fair game for anything that walks in the front door—from a 3-year-old with an ear infection, to a 40-year-old with a possible heart attack, or an elderly patient with hypertension. Two and a half days a week, he staffs the Long Prairie Medical Center satellite clinic in Clarissa, a small town of less than 600 people, north of Sauk Center.

He's not a doctor, and his patients know it. But Helgeson's broad-based medical training as a physician assistant and 18 years of experience enable him to provide many patients with a level of primary care they would expect from a doctor.

"That doesn't mean I can take care of everything," Helgeson is quick to explain. "It's up to me to recognize when a condition is outside my realm of experience, and that I need to refer that patient to a physician. The supervising physicians I work with trust that I know where that line is; a regular review of my charts shows them that I do."

A number of studies in recent years have shown that physician assistants and advanced practice nurses (APNs) can effectively provide a high percentage of the routine care normally handled by physicians, freeing doctors to handle more complex cases and procedures.

"I foresee more and more interdisciplinary activity in clinical and ambulatory settings, with physicians and nonphysician professionals working side by side," says William Jacott, M.D., assistant vice president for health sciences at the University of Minnesota and a family physician. "The level of care required and severity of a patient's problem will determine who provides the care."

Often nonphysician practitioners' schedules allow them to respond more rapidly to patient phone calls and fit in more same-day appointments. In addition to providing routine and episodic

Nonphysician practitioners have become key members of the health care team, but the scope of their practice is still under debate.



Pediatric nurse practitioner Mary Beth Hanson.

acute care, they are usually able to spend more time than a physician providing patient education and follow-up management for chronic conditions such as diabetes and hypertension.

Down in the far southeast corner of the state, in a small rural clinic in Caledonia, certified nurse practitioner and midwife Deb Miller and family physician Alan Fleischmann, M.D., have been working col-

A measure of independence

laboratively for several years.

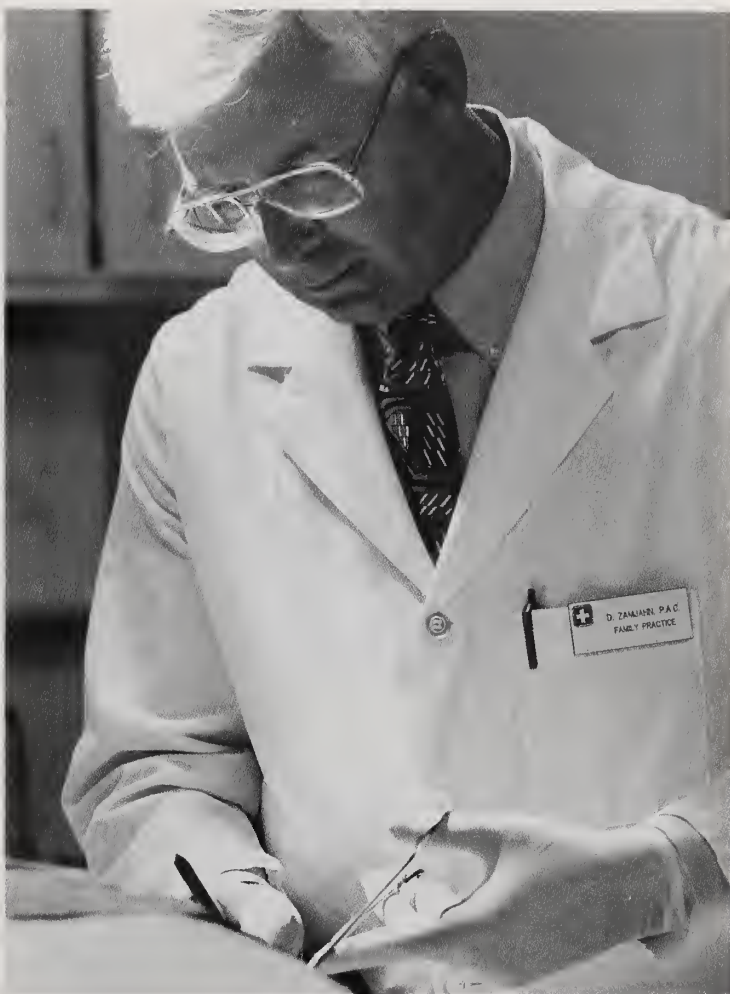
"Deb plays a special role at our clinic," says Fleischmann. "She has an understanding of women that is quite profound." He notes that Miller's schedule allows her to take more time to deal with a patient's emotional issues and the relationships involved, something that a physician's schedule may not permit. "Different practitioners have different approaches, and patients like to have a choice," he says.

In turn, Miller describes her relationship with Fleischmann as one of trust and mutual respect for the other's expertise. "I don't feel like I'm the underdog," says Miller. "We have a very collegial relationship and consult with each other frequently. I'm very autonomous and individual in my practice, but I also know what I don't know, and when I need to refer a patient to a doctor."

COST-EFFECTIVE, QUALITY CARE

Utilizing nonphysician practitioners (NPPs) as part of a health care team also provides definite financial advantages, says Theresa Ryan, M.D., medical director of Park Nicollet Clinic HealthSystem Minnesota. "The cost of care has to be watched very carefully," she says, noting there still are substantial differences in the salaries of physicians and NPPs. A 1994 survey of physician assistants by the Minnesota Academy of Physician Assistants (MAPA) indicated a salary range from an average of \$43,300 for new graduates up to \$71,500 for the most experienced PAs. Results of a survey of nurse practitioners last year by the Third District Minnesota Nurses Association showed a median annual-equivalent salary of \$48,300, with the highest salaries reported at about \$70,700.

"When looking at the functions of the team members in a group practice, you realize that a great deal can be done by nonphysicians," Ryan says. "They can provide the same quality of care [within the scope of their training and experience] at a lower cost." For example, it is much more costly for a



Physician assistant David Zamjahn.

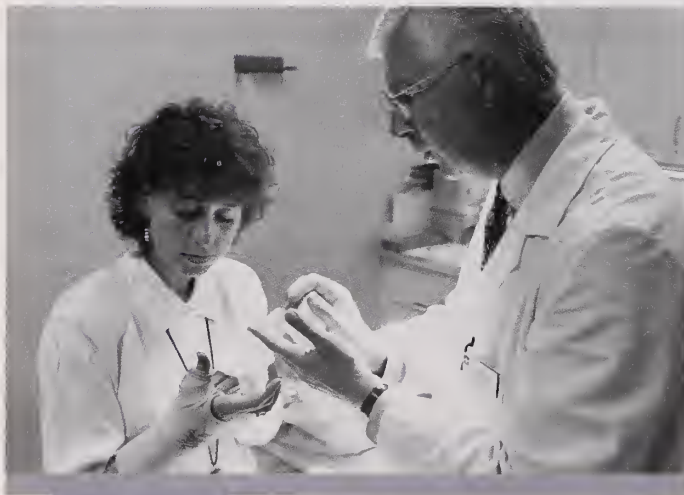
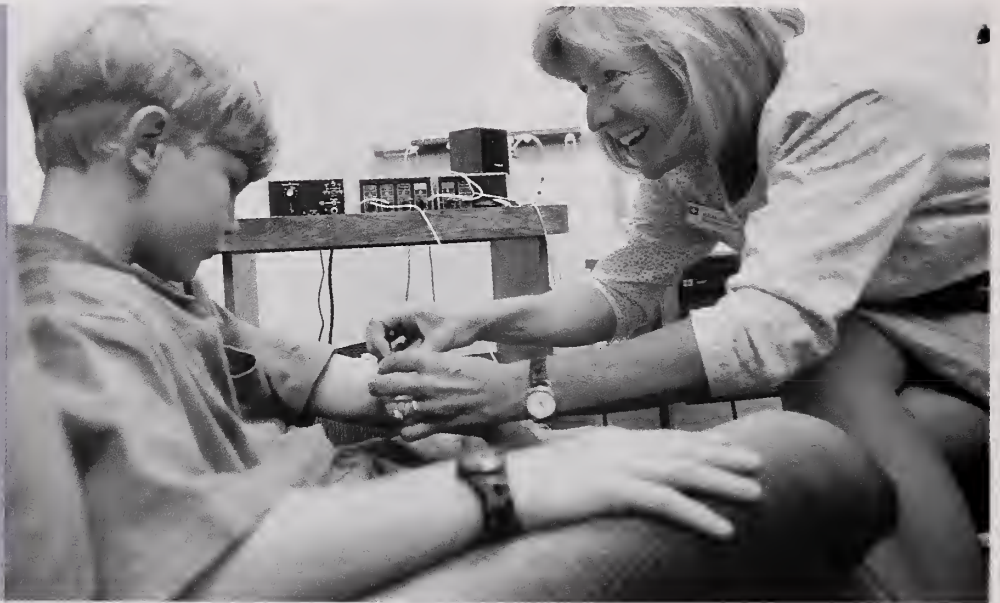
physician to spend an hour doing patient education than a nurse practitioner, Ryan notes.

At present, Park Nicollet Clinic employs 29 nurse practitioners and four physician assistants and is exploring the idea of adding certified nurse midwives to the practice. The clinic also has a teaching program, serving as a clinical site for nurse practitioner students from the College of St. Catherine and the University of Minnesota. It also will be a training site for the recently opened physician assistant program at Augsburg College in Minneapolis.

"Patients love the care they receive [from nurse practitioners and physician assistants]," says Ryan. "We hardly ever get complaints. Some patients may come with their own biases, but most of the time, once they have seen one of our nurse practitioners or

Story by Katie Colón ... Photos by Richard Anderson

Pediatric nurse practitioner Rebecca Kajander often helps young patients deal with chronic pain. Biofeedback, as shown here at Park Nicollet's Bloomington clinic, is one procedure she uses.



PA David Zamjahn shows a patient how to care for her cast.

physician assistants, they are quite pleased and want to come back."

Acceptance by patients is high, agrees David Zamjahn, who was the pioneering physician assistant in the Park Nicollet system when he began work-

ing at the Minnetonka clinic 17 years ago.

"A greater hurdle [than achieving patient accep-

tance] is gaining acceptance from physicians," says Zamjahn. "They may worry about how much time they will need to invest in supervising a PA, especially a new graduate. There is definitely more work involved at first, more time spent reviewing. But the relationship is definitely beneficial in the long run."

Stephen Leenay, M.D., one of Zamjahn's supervising physicians, agrees. In addition to providing routine primary care, Zamjahn performs minor surgeries, such as corn removal and skin biopsies, attends to lacerations, sets fractures, and does other trauma intervention. "It's very convenient for patients who might otherwise be referred to the main center for some of these procedures," explains Leenay. Having Zamjahn in the practice allows Leenay to dedicate more time to problems appropriate to an internist, he says.

While there are those who fear that the growing numbers of nurse practitioners and physician assistants providing primary care represent a competitive threat to family physicians and other generalists, the current shortfall of family physicians still exceeds the number of graduates entering the marketplace each year.

According to the Medical Search Institute in Overland Park, Kansas, 2,255 family physicians will graduate from medical school this year, with a

conservative estimate of 15,000 open positions nationwide. For each of the 1,800 physician assistants who will graduate this year, an estimated seven to nine jobs will be available.

Determining the number of health care professionals that will be needed in the work force in coming years is very difficult, says Jacott. "Many people feel we are turning out too many physicians, too many specialists, in particular. The exact numbers of physicians needed depends on the region, locale, and demographics of the population in a given area." Are they mostly young people, or elderly? Is it an area with a high incidence of endemic problems such as violence? Whether or not physicians feel their practice is threatened depends on all these factors, Jacott says.

THE DECISION TO CHOOSE A PA OR AN NP

Currently, there are an estimated 295 registered physician assistants and 1,000 nurse practitioners in Minnesota. The vast majority of the state's nurse practitioners are women (95 percent of Minnesota's registered nurses are women, according to the Third District Minnesota Nurses Association). Physician assistants are more evenly matched—57 percent men and 43 percent women, as reported in MAPA's 1994 survey results. The decision to hire either a nurse practitioner or physician assistant probably depends on the needs of the practice and patient population being served, says Faith Zimmerman, certified family nurse practitioner and graduate faculty member in the Adult Nurse Practitioner Program at Winona State University.

If the clinic practice is looking for a health care provider with medical training that closely parallels that of a physician, or someone with a high level of specialized skills (such as a surgeon needing surgical

Ob/gyn nurse practitioner Christine Taylor-Rogers conducts prenatal visits; performs ultrasounds, Pap smears, and pelvic exams; and educates patients on women's health issues.



assistance), that practice may want to choose a physician assistant. If the clinic wants a health care provider whose specialty is health promotion and patient education services, in addition to primary care, a nurse practitioner is the right choice, says Zimmerman.

PHYSICIAN ASSISTANTS

According to MAPA, about 60 percent of the state's physician assistants work in primary care—including family practice, internal medicine, pediatrics, and ob/gyn—while about 40 percent practice in surgical or other subspecialty areas. Nearly one-third of the state's physician assistants work in communities of less than 20,000, and about 16 percent in areas of less than 5,000.

On May 30, the state's first physician assistant training program in nearly 20 years started at Augsburg College in Minneapolis with 24 students. The state's only other program, at St. Cloud State University, closed in the mid-1970s after failing to achieve accreditation. In the interim, the neighboring University of Wisconsin-Madison has offered a training program that graduated its first class in 1977. In the fall of this year, the University of Wisconsin-La Crosse will also open a physician assistant program in a joint venture with the Mayo Clinic and the Gundersen Clinic of La Crosse. Mankato State University is likewise in the process of developing an additional program in Minnesota.

Typically, physician assistants train for the practice of medicine in two-year programs that are often compared to the first and third years of medical school. Traditionally, students have entered a physician assistant program with some college background and health care experience, notes Carroll Poppen, PA-C, president of MAPA. However, the majority of the physician assistants now in training have a bachelor's degree, and the trend is toward selecting candidates with a stronger academic background than previously, he adds.

The Augsburg program will include 12 months of classroom study in such areas as anatomy, bio-

chemistry, genetics, pathology, physiology, and pharmacology, and 15 months of clinical rotations in family practice and a number of other medical disciplines. Board certified by the National Commission on Certification of Physician Assistants (NCCPA), physician assistants practice medicine under the supervision of a physician and are registered with the Minnesota Board of Medical Practice.

By law, a physician assistant and his or her supervising physician must sign an agreement specifying the PA's scope of practice and the manner in which the physician assistant is to be supervised. The agreement also includes an internal protocol if the physician delegates prescribing, administering, and dispensing privileges to the physician assistant. Previously, Minnesota required that a physician assistant have the on-site supervision of a physician for 20 percent of patient care time. However, legislation passed this year removed that requirement, allowing more flexibility in how the supervisory relationship is managed, explains Bev Kimball, PA-C, chair of MAPA's governmental affairs committee. The new law also allows the supervising physician to delegate controlled substance prescribing, if appropriate, to his or her physician assistant. Delegation often varies according to the physician assistant's level of experience.

Advanced Practice Nurses

Nurse practitioners are only one of four groups that fall under the definition of advanced practice nurse. While the vast majority of clinical specialists and nurse anesthetists practice in hospital settings, certified nurse midwives often work in collaborative relationships with obstetricians in a variety of settings. Here are a few more facts about advanced practice nurses and certified nurse midwives in Minnesota.

Advanced practice nurses: Have an advanced level of nursing education beyond the basic two- to four-year education required for registered nurses. To be certified, they must meet the criteria of their respective national certifying organizations. APNs include nurse practitioners, certified nurse midwives, nurse anesthetists, and clinical specialists in psychi-

atric and mental health nursing.

Certified nurse midwives: Have advanced education in the provision of care for women and infants through all stages of the birthing process, from prenatal to postpartum care. They also provide routine gynecological care. Certification is through the American College of Nurse Midwives. CNMs can practice independently, although they must have access to a physician for emergency and complex medical situations. They also have independent prescribing authority. Two CNM training programs are currently offered in Minnesota—a master's-level degree from the University of Minnesota and a pre-certification program at Ramsey Clinic in St. Paul for international nurse midwives who wish to become certified in this country.

NURSE PRACTITIONERS

Minnesota currently has education programs for nurse practitioners at five academic institutions: the College of St. Catherine, the University of Minnesota, the College of St. Scholastica, Winona State University, and Mankato State University. In addition to a bachelor's degree in nursing, the typical nurse practitioner student has several years of nursing experience prior to starting an advanced education program. Most programs of study now require a master's-level degree (two-year program of study) to become a nurse practitioner. Nurse practitioner coursework includes studies in pathophysiology, clinical pharmacology, research, advanced assessment, health promotion, management of common acute and chronic conditions, plus significant time in clinical settings with nurse practitioner and physician preceptors.

Graduates are certified by the American Nurses Credentialing Center and other national credentialing bodies. They practice within a variety of clinical specialties, including pediatrics, family practice, geriatrics, and women's health care. Physician supervision of nurse practitioners is not delineated in Minnesota, although certain medical functions (such as prescribing privileges and the authority to order lab tests, x-rays, or physical therapy) must be delegated by a physician under a collaborative agreement with the nurse practitioner.

Nurse practitioners take a holistic approach to health care that includes evaluation, prevention, and intervention, according to Marilyn Cunningham, R.N., executive director of the Minnesota Nurses Association. "A nurse practitioner adds another dimension to the patient/caregiver relationship," she says, noting that family and pediatric practices have traditionally worked very closely with nurse practitioners. They work with the patient as a partner, looking not only at the current health problem, but also the family systems involved, what prevention is needed, and what follow-up and support should be provided.

SCOPE OF PRACTICE AND AUTONOMY ISSUES

With more and more nurse practitioners providing primary care in a variety of settings and practices,



Patient education can mean talking to parents and their kids for pediatric nurse practitioner Rebecca Kajander.

the issues of provider autonomy and scope of practice are being debated nationally. In early 1994, the Clinton administration's support of greater independence for nurse practitioners as part of national health care reform spawned new talks between the American Medical Association and the American Nurses Association to discuss collaboration and scope of practice. The collapse of national health system reform mid-year, however, brought the AMA/ANA talks to a standstill, and the issue of autonomy for nurse practitioners remains a major rift between the two organizations.

continued

In addition to health promotion and education services, nurse practitioners essentially provide defined levels of care for the screening, diagnosis, and management of common acute and chronic conditions, says Zimmerman. "NPs are able to be autonomous within that scope of practice, as defined by their education and level of experience."

Autonomous practice would include consulting with and making appropriate referrals to a physician when a patient's needs fall outside the nurse practitioner's level of experience and expertise, explains Zimmerman. "It is comparable to a family physician making an appropriate referral to a specialist. All topics covered in class—for example, hypertension and diabetes—are presented with information regarding appropriate collaboration and referral. The main concern is always the delivery of safe, quality patient care."

Some doctors, however, ask whether individual practice by APNs is actually the practice of medicine or of nursing, says Jacott, who has chaired the AMA discussions with the ANA since early last year. "Patient safety is an issue," he says.

"My own opinion is that every health practitioner will soon be aligned with some kind of network or system," says Jacott. "The ability for anybody to set up individual practice is going to be a moot subject. To argue or debate that issue is not a good use of time. What we need to do is learn to work together

for the benefit of the patient. We need to define the scope of practice for each of those groups within an integrated system."

Despite the national debate, Cunningham believes nurse practitioners (and other advanced practice nurses) will continue to benefit from incremental advances in health system reform in Minnesota.

"We hope that health care reform will come to recognize the contributions that all nurses make to the health care system, that it is a partnership, and that no one profession holds all the answers," says Cunningham. "We look to expand payment options so that all advanced practice nurses will have the right to bill and be reimbursed directly by all third-party payers." She notes that while some nurse practitioners do currently receive third-party reimbursements, there are payers who will not directly reimburse nonphysicians.

Unlike nurse practitioners, physician assistants as a group, both in Minnesota and nationwide, do not seek independent practice. They are committed to their role as dependent practitioners, practicing medicine under the supervision of a licensed physician.

As a member of the Physician Assistant Advisory Council to the Board of Medical Practice, Mark Helgeson says part of his job is to look after the

NONPHYSICIAN PRACTITIONERS cont. on page 49

At many hospitals, physicians battle every day with things invisible to the naked eye.

At North Memorial, we think you should spend less time worrying about your career and more time worrying about your patients. That's why we believe in policies that are also beneficial to Internal Medicine and Family Practice Physicians. If you'd like to practice in a truly innovative medical community in Minneapolis or a surrounding suburb, call a Physician Placement Coordinator at 1-800-275-4790.

Such as hospital policies.

Upgrade Your Vacation With National Car Rental.



National Car Rental®/Interrent® keeps you moving with special coupons and rental offers you can use nationwide, throughout the year. And as the official car rental company of Walt Disney World® and Disneyland®, National® lets you share the Disney magic with an exciting special offer. So now you can have an even better vacation with National.

One Free Weekend Day (With Purchase of Two).

Present this certificate at National's rental counter to receive one free weekend day with purchase of two or more weekend days at the applicable weekend rates. Valid on a Compact through 4-door Full-size car at participating National locations in the United States. Reservations required. Contact your travel consultant or National at 1-800-CAR-RENT. Subject to terms and conditions listed on reverse side. Discount # 5708482. Valid through December 31, 1996.



The official car rental company of Walt Disney World, Disneyland, and Walt Disney's Magic Kingdom Club.

Call 1-800-CAR-RENT®

One Free Weekend Day (With Purchase of Two).

Present this certificate at National's rental counter to receive one free weekend day with purchase of two or more weekend days at the applicable weekend rates. Valid on a Compact through 4-door Full-size car at participating National locations in the United States. Reservations required. Contact your travel consultant or National at 1-800-CAR-RENT. Subject to terms and conditions listed on reverse side. Discount # 5708482. Valid through December 31, 1996.



The official car rental company of Walt Disney World, Disneyland, and Walt Disney's Magic Kingdom Club.

Call 1-800-CAR-RENT®

One Car Class Upgrade

Present certificate at National's rental counter to receive a one car-class upgrade on a Compact through 2-door Full-size car. Highest obtainable upgrade is to a 4-door Full-size car. Valid at participating National locations in the United States. Reservations recommended. Contact your travel consultant or National at 1-800-CAR-RENT. Subject to terms and conditions listed on reverse side. Discount # 5708482. Valid through December 31, 1996.



The official car rental company of Walt Disney World, Disneyland, and Walt Disney's Magic Kingdom Club.

Call 1-800-CAR-RENT®

Fall Fantasy At The Walt Disney World Resort

From August 27 to November 20, 1995, it's a new season of fantasy at The Walt Disney World Resort. Disney's Fall Fantasy packages include accommodations at a selected Disney resort hotel, daily Character Breakfast or selected Disney resort breakfast, and a coupon book worth up to \$500 in Walt Disney World special values. Three night packages start at \$149 per person, based on adult double occupancy. Ask about our special savings for midweek packages in September. For reservations and information call your travel agent or 407-827-7200 and ask for National's Fall Fantasy Package.



Disney's new All-Star Music Resort



The official car rental company of Walt Disney World, Disneyland, and Walt Disney's Magic Kingdom Club.

© The Walt Disney Company

CERTIFICATE TERMS AND CONDITIONS:

Valid for one weekend day with purchase of two or more weekend days for car class indicated at participating National locations in the United States (Not valid in Manhattan, NY). Subject to availability, blackout dates and capacity control. Weekend rate and time parameters, local rental and minimum rental day requirements apply.

Cannot be used in multiples or with any other certificate or special promotion. Standard rental qualifications apply.

Minimum rental age at most locations is 25. In addition to rental charges, where applicable, renter is responsible for:

Optional Loss Damage Waiver, up to \$13.99 per day; a per mile charge in excess of mileage allowance; taxes; sur charges; additional charges if car is not returned within prescribed rental period; drop charge and additional driver fee; optional refueling charges; optional insurance benefits.

Rental Agent Instructions: 1. Rental Screen 1 key 7 in "Type" field. 2. Rental Screen 3 key Discount ID in "Rate Recap" field and key applicable rate for one weekend day in "Dep Orig" field. 3. Write RA # and rental date below.

4. Retain certificate. Send certificate to Headquarters.

ATTN: Travel Industry Billing.

RA # _____ Rental Date: ____/____/____.

CERTIFICATE TERMS AND CONDITIONS:

Valid for one weekend day with purchase of two or more weekend days for car class indicated at participating National locations in the United States (Not valid in Manhattan, NY). Subject to availability, blackout dates and capacity control. Weekend rate and time parameters, local rental and minimum rental day requirements apply.

Cannot be used in multiples or with any other certificate or special promotion. Standard rental qualifications apply.

Minimum rental age at most locations is 25. In addition to rental charges, where applicable, renter is responsible for:

Optional Loss Damage Waiver, up to \$13.99 per day; a per mile charge in excess of mileage allowance; taxes; sur charges; additional charges if car is not returned within prescribed rental period; drop charge and additional driver fee; optional refueling charges; optional insurance benefits.

Rental Agent Instructions: 1. Rental Screen 1 key 7 in "Type" field. 2. Rental Screen 3 key Discount ID in "Rate Recap" field and key applicable rate for one weekend day in "Dep Orig" field. 3. Write RA # and rental date below.

4. Retain certificate. Send certificate to Headquarters.

ATTN: Travel Industry Billing.

RA # _____ Rental Date: ____/____/____.

PROGRAM TERMS AND CONDITIONS:

1. Reservations must be booked in advance and are subject to availability. 2. Offer does not apply to vacation plans, group rates or any other special promotion. 3. Minimum stay of three nights required. 4. Offer valid August 27 through November 20, 1995 at selected Walt Disney World Resort hotels. 5. \$149 lead in price based on Disney's All-Star Resorts, adult double occupancy.

PROGRAM TERMS AND CONDITIONS:

Valid for car classes indicated at participating National locations in the United States (Not valid in Manhattan, NY). Subject to availability and blackout dates. Local rental rate parameters and minimum rental day requirements apply. Cannot be used in multiples or with any other certificate or special promotion. Standard rental qualifications apply. Minimum rental age at most locations is 25. In addition to rental charges, where applicable, renter is responsible for: Optional Loss Damage Waiver, up to \$13.99 per day; a per mile charge in excess of mileage allowance; taxes; sur charges; additional charges if car is not returned within prescribed rental period; drop charge and additional driver fee; optional refueling charges; optional insurance benefits. Rental Agent Instructions: 1. Key Discount ID Number in "Rate Recap" field on rental screen 3. 2. Charge rate for one car class lower than class of car actually rented. 3. Retain certificate at rental. Write RA # and rental date below. 4. Send certificate to Headquarters. ATTN: Travel Industry Billing.

RA # _____ Rental Date: ____/____/____.

Should a Geriatric Nurse Practitioner Become Part of a Multispecialty Group?

Barbara P. Yawn, M.D., M.S., and G. Richard Geier Jr., M.D.

ABSTRACT

The addition of a geriatric nurse practitioner to the staff of a medical group that visits nursing home residents appears to offer benefits to the professional staff, the nursing home staff, and the nursing home residents, according to interviews with nursing home personnel and the physicians and administrators of the multispecialty group providing medical services to the nursing homes.

Care of nursing home residents is uncomfortable for many physicians who lack training in the care of patients outside the hospital or their offices.¹ Visits to nursing homes are financially unrewarding and can be frustrating.² The amount of paperwork and required assessments can leave the physician little time to visit residents or their families in a manner that considers the slow pace or impaired mental status of many nursing home residents.

Most nursing homes are staffed by one or two registered nurses, a few licensed practical nurses, and a cadre of nursing assistants.³ Only the registered nurses are likely to have the skills necessary for more than cursory assessment of a resident's acute or chronic medical condition.^{4,5} Many employees are overworked, and they may not take time to complete or update the assessment associated with the simplest of functions, such as eating, drinking, and toileting.^{4,6}

According to Kayser-Jones and her colleagues, the results of these staffing problems include deteriorating health of residents, excessive and unnecessary hospitalization rates, and frustrated nursing home staffs, physicians, and residents' families.^{6,7} The inclusion of geriatric nurse practitioners (GNPs) in nursing home practice has been proposed and tested as a solution to these problems.⁸

Several researchers have studied the addition of GNPs to the nursing home staff.²⁻¹¹ Kane et al. studied 30 nursing homes and found that the addition of GNPs was associated with modest, favorable changes in the residents' average activities of daily living scores, reductions in some types of drug treatment, and a decrease in hospital admissions and length of hospital stays.^{9,10}

Many of these studies rely entirely on quantitative measures of nursing home residents' drug use, assessed function, and rates of hospitalization.^{6,7,9} They fail to address important social and other non-clinical factors associated with the care of nursing home residents upon which a GNP may have significant impact.⁴⁻⁶ Such factors include staff-physician ease of communication, job satisfaction, and resident and family comfort.⁶

This study used structured researcher-administered interviews to explore nursing home staff and physician assessments of several clinical and nonclinical functions necessary to care for nursing home patients. The interviews allowed qualitative assessment from the perspectives of nursing home personnel, as well as physicians and administrators from the multispecialty group providing medical services. The interviews were timed so that personnel from each nursing home could be interviewed within six months of losing a GNP's services or within three months of gaining a GNP's services for the first time. The study's goal was to identify perceived advantages and disadvantages to the staff, residents, and physicians of including a geriatric nurse practitioner in a multispecialty medical group caring for nursing home patients in several facilities. These advantages and disadvantages may be overlooked in outcomes studies that do not include process of care assessments.

METHODS

The Olmsted Medical Group (OMG) is a 70-physician multispecialty group with offices in Rochester, Minnesota, and eight nearby rural communities spread over six counties. The group cares for residents in five Roch-

ester and nine rural nursing homes. Each nursing home has a physician designated to care for its residents; no other physicians in the group provide services to residents in a home except on an emergency or inpatient basis.

The Olmsted Medical Group first employed a GNP to provide nursing home services in 1972. She made weekly visits to all Rochester-based nursing homes and one of the nine rural facilities served by OMG physicians. She was the first GNP to serve any of the area's nursing homes. In June 1993, the GNP left Olmsted Medical Group, and a replacement was not immediately found to serve the Rochester nursing homes. However, in August 1993, a new GNP

was added to the staff to serve four of the rural nursing homes.

Structured interviews were completed in all involved nursing homes with the head nurses or directors of nursing and the daytime charge nurses, except one nurse who was on maternity leave and unavailable. In addition, all physicians who visit nursing homes were interviewed, as well as the Olmsted Medical Group's administrator, president, and medical director. The questions varied slightly among the groups, but each person was asked about the role of the GNP, changes that occurred after the departure of the first GNP, changes that occurred after the new practitioner started work, positive and negative aspects of including a GNP in

the care of nursing home patients, and the qualities and qualifications important in the selection of a GNP. Thirty-five interviews were completed; three with administrators of the medical group, 12 with physicians, 17 with nursing home nurse supervisors, and three with nursing home administrators. No patients or patients' families were interviewed.

RESULTS

The results of the interviews are summarized in three categories: administrators of Olmsted Medical Group (the multispecialty group employing the physicians and GNP), nursing home staff, and physicians.

MEDICAL GROUP ADMINISTRATION

The management group of the Olmsted Medical Group (president, medical director, and administrator) makes the decisions to add new staff positions and new categories of staff members to the multispecialty group.

All three members of the management group believed that GNPs were of considerable value to the organization, the physicians, the nursing homes, and the residents served by the Olmsted Medical Group. The advantages that administration saw for the nursing home residents and staff were primarily the extended time a GNP is able to spend in the nursing home. Both administrative physicians said they believed that the GNP would likely find the nursing home practice more stimulating than would physicians. They also said a GNP might recognize "minor" problems earlier, which could potentially decrease patient hospitalization.

All three OMG administrators believed physicians would find nursing home practice more pleasant and rewarding because the GNP could reduce the physicians' paperwork and handle telephone calls for minor problems, both of which would increase the physicians' productivity.

The administrators described two disadvantages of using a geriatric nurse practitioner: physicians may become more removed from day-to-day patient care, and liability risk may increase with the addition of a nonphysician practitioner.

Table 1

Advantages of a GNP: the nursing home staff perspective

Availability

- increased visit frequency
- increased length of time per visit
 - better understanding of how care is given
 - actual observation of patient in the nursing home setting
- increased continuity of care
- more prompt assessment for admission orders

Access

- fewer barriers to medical care
 - on-site assessment for acute problems vs. visit to emergency department or office
 - easier access to emergency orders
 - earlier consultation about "minor" problems

Appropriate level of care

- provide "practical" home remedies
 - simple skin care
 - eating/feeding techniques
 - non-medication therapy for behavior problems
- interact with families regularly
- complete paperwork weekly
- schedule routine or required assessments in nursing home
- provide hospice-like services
- provide nail care and ear washing without extra charge to patients

Prevention of hospital admissions

- "catch problems early" (UTI, CHF, URI)
- evaluate acute problems on site instead of in emergency department
- increase on-site service
 - TPN
 - IV antibiotics
- increase communication with families to assess desires and to educate about possibilities (DNR, comfort-only care)
- allow in-home alternatives with daily monitoring
- provide and monitor "comfort" care on site

NURSING HOME STAFF

The nursing home staff described advantages to patients that were very similar to those listed by Olmsted Medical Group's administrators. However, the staff provided much greater detail. They summarized the advantages in four major areas: increased availability, increased access, attention to the unique problems of nursing home residents, and prevention of hospital admissions. These items are listed in Table 1 (see page 18) in order of the frequency they were mentioned.

The responses from staff at one nursing home varied significantly from the other responses. The three staff interviewed from this facility said they did not like the possibility that the GNP would "get in the middle" of the care. They believed they could do a better job assessing the patients' needs and talking with the physician because they knew the residents better. They thought the GNP "talked down to them" and did not listen to their concerns. This nursing home was served by the same nurse practitioner who saw patients at four of the other facilities whose staff saw no major disadvantages to employing a GNP.

All the remaining nursing home nurses and administrators felt that the GNP provided benefits to the staff. They felt that communications regarding patient care improved because it is easier to talk with a nurse than with a physician. The nurses said the GNP educated the nursing home staff on several levels, including sharing information on treatment strategies and the aging processes, and providing basic knowledge of diseases. The nursing home staff believed the GNP fostered a "team" approach to patient care that bridged the gap between nursing care, personal care, and medical care.

Staff members of four nursing homes (40% of the sample) cited some disadvantages to employing a GNP. Three of the four said they believed that direct communication between the staff and the physicians was not as comfortable as it was or would be without a GNP because of the reduced need of the nursing home

Table 2

*Advantages and disadvantages of a GNP: physician perspective***Advantages**

- fewer practice disruptions for physicians
 - telephone calls
 - unscheduled nursing home visits
- more frequent contact with patients and families by GNP
- prevention of emergency department and office visits
- better assessments of patients with acute problems than available from nursing home staff alone

Disadvantages

- paper care instead of patient care
- less knowledge of patients
- no reimbursement for supervision services
- must learn to work with and supervise another professional
- less contact with nursing home staff

staff to get to know the physician and to communicate directly with the physician.

PHYSICIANS

The physicians had a slightly different opinion of the value of including a GNP. The Olmsted Medical Group has 10 physicians who visit nursing homes that have or have had a GNP assigned to them. These physicians serve one to three nursing homes each (an average of two) with total patient volume of 12 to 80 residents each (an average of 30 per physician). The physicians have been caring for nursing home patients for one to 17 years (an average of five years).

Although all physicians agreed that employing a GNP has advantages, they saw fewer potential advantages and more disadvantages than either the medical group administrators or the nursing home staffs.

Table 2 lists the advantages and disadvantages in order of frequency as reported by the physicians. Since the loss of the GNP, the amount of time physicians spend at the nursing homes has not changed, according to both their impressions and the actual number of hours they have been out of the office and at the nursing homes. However, several patients from the nursing homes now come to the office for their regular annual or semi-annual physical examinations. These are examinations that had been done by the GNP in the nursing home and were then reassessed by the physician during nursing home visits.

The physicians' opinions of how their roles are different in the nursing homes with and without the GNP services varied depending on the amount of time the physician worked with a GNP. Those physicians who worked with the GNP the longest felt that they are in the nursing homes only to meet regulatory requirements by validating what the GNP did; primarily, they sign paperwork so the GNP will be reimbursed for her services. These physicians said they would like a system that could truly increase their efficiency without switching their role from patient care to paperwork.

Physicians who had only recently acquired the assistance of a GNP said their jobs changed little. These physicians said they continued to provide acute care, update records, and make required visits as scheduled by the nursing home staff. The physicians believed the GNP simply shared these duties.

IMPORTANT QUALIFICATIONS
AND CHARACTERISTICS

All interviewees were asked to state the most important qualifications and requirements for the nursing home GNP. All three groups of interviewees had similar recommendations. Table 3 (see page 20) lists the recommendations in order of importance to the people interviewed. In addition, all physicians wanted to make certain that the GNP was certified and able to sign non-medication orders without physician co-signature. The phy-

Table 3

Recommended qualifications of a nursing home nurse practitioner

- Geriatric nurse expertise:**
- specific geriatric nurse practitioner training
 - experience in long-term care, hospice care, or nursing home care
 - possession of basic personal care skills
 - skin, foot, and nail care
 - ear washing
 - IV therapy maintenance
 - registration and licensure to facilitate full range of allowable practice
 - ability to take night call for nursing homes

- Communication skills:**
- skills in communicating with
 - nursing home staff
 - physicians
 - the elderly
 - families of residents

- Teaching skills:**
- skills in instructing
 - patients and families
 - nursing home staff
 - other professionals, including physicians

- Team skills:**
- ability to facilitate and foster team approach

sicians emphasized that the GNP must have experience caring for elderly patients and must know the limits of his or her skills and abilities. The nursing home staffs were most concerned that the nurses have good working relationships with the physicians so that they are an effective liaison rather than a barrier.

QUANTITATIVE ASSESSMENT

Although the time since the practice changes (either loss of the Rochester GNP or addition of the rural GNP) has been too short for extensive quantitative assessment, some data are available. The rate of visits to physicians' offices and emergency departments was assessed and is higher without the GNP, 3.4 visits per 100 resident days in the nursing home vs. 1.3 with the GNP ($p=.03$).

DISCUSSION

Physicians were less enthusiastic about employing a GNP than were administrative or nursing home staff. This is not surprising, since physicians did not see the increased pro-

ductivity and efficiency expected by the group administrators. Nor did the physicians realize an increase in the time they spent on patient care, but merely believed they had more forms to co-sign and another person to supervise. The physicians were pleased that the GNP could make weekly nursing home visits and could recognize and assess minor problems in a timely manner, thus preventing physician visits to emergency departments, and perhaps preventing some hospital admissions.

The physicians who are just starting to work with the new rural GNP hope her employment will increase services to the patients and further improve communication with the nursing home. However, they are uncertain about what direct benefit the nurse will bring to their practices. They hope that phone calls and unscheduled visits to the nursing homes will decrease, but they do not believe their scheduled time spent in the nursing home will otherwise change. Making the nurse an employee of the medical group staff rather than the

nursing home may help physicians see the advantages of this program. Being part of the same organization forces both physicians and GNPs to examine their roles and develop ways to share care and responsibilities.

The nursing homes appear to have realized several benefits from hiring a GNP. In fact, one nursing supervisor commented that she did not want to admit any more new patients until a GNP was hired to increase access and availability of medical services. Of the groups surveyed, the nursing home staffs were most enthusiastic about the benefits of employing a GNP. The one nursing home that did not find the GNP helpful did not appear to be any different from the other nursing homes. The difference in attitudes may lie in personal preference of the nursing supervisor, who was also serving as acting administrator at the time of the interviews. No other personnel from this facility were available for comment, according to the nurse interviewed.

CONCLUSION

According to medical group administrators and nursing home staff members, the inclusion of a geriatric nurse practitioner in a multispecialty group provides several advantages to the residents and staff of nursing homes, including greater frequency and duration of health care services. The physicians providing care to the nursing home residents relate fewer advantages. Although cost-benefit analysis is beyond the scope of this paper, the decreased use of expensive emergency department visits by residents in nursing homes served by a GNP appear to favor the inclusion of a GNP in the nursing home practice. To be effective, the GNP must have good communication, team-building, and clinical skills. MM

Barbara Yawn is a family physician and director of clinical research at the Olmsted Medical Group in Rochester, Minnesota. Richard Geier is a general surgeon and president of the Olmsted Medical Group.

Copies of the structured interviews used in this study can be obtained by contacting Barbara Yawn, M.D., at

Olmsted Medical Group, 210 Ninth Street SE, Rochester, MN 55903.

REFERENCES

1. Gambert SR, Rosenkranz WE, Basu SN, Jewel KE, Wings ER. Role of the physician extender in the long term care setting. *Wis Med J* 1983;82:30-2.
2. Mezey MS, Scanlon W: Reimbursement options for encouraging geriatric nurse practitioner services. In: *Nursing homes and nursing home care: lessons from the teaching nursing homes*. New York: Springer, 1989.
3. Minnesota Department of Human Services and the Institute for Health Services Research, University of Minnesota School of Public Health. Long-term care for the elderly. Minneapolis: Institute for Health Services Research, 1986.
4. Gray P. Gerontological nurse specialist: luxury or necessity? *Am J Nurs* 1982;82:82-5.
5. Chaffin P. Nurse practitioners: nursing contribution to quality care in nursing homes. *Nurse Practitioner* 1976 May-June; 24-6.
6. Kayser-Jones JS, Wiener CL, Barbaccia JC. Factors contributing to the hospitalization of nursing home residents. *Gerontologist* 1989;29:502-10.
7. Ouslander JG. Reducing the hospitalization of nursing home residents. *J Am Geriatr Soc* 1988;36:171-3.
8. Bynum GD, Jelinek D, Smith J. A medical director's view of the GNP in the nursing home. *J Long Term Care Adm* 1983;11:34-5.
9. Kane RL, Gabbard J, Skay CL, et al. Effects of a geriatric nurse practitioner on process and outcome of nursing home care. *Am J Public Health* 1989;79:1271-7.
10. Garrard J, Kane RL, Radosevich DM, et al. Impact of geriatric nurse practitioners on nursing-home residents' functional status, satisfaction, and discharge outcomes. *Med Care Adm* 1990;28(3):271-83.
11. Nuemann B. Cost-effectiveness issues and research studies. *J Long Term Care Adm* 1983;11:48-53.

Creative solutions for all your health law problems



Leonard, Street and Deinard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

Physician Reviewers

Health Risk Management provides comprehensive health care quality management and information services based on our nationally recognized healthcare practice guidelines. The continuing growth of our care management business requires additional part-time consulting physicians to apply clinical expertise to patient care review. You will work within your medical specialty field to provide care review services and serve as an educational resource to our clinical staff.

We are seeking physicians with backgrounds in:

- ORTHOPEDICS
- OB/GYN
- NEUROLOGY

To qualify, you must be actively licensed and board certified, have related experience, and knowledge of managed health care.

We offer:

- Competitive pay
- Opportunity to complement your expertise
- Flexible part-time schedules including day, evening and on-call night shifts on weekdays and weekends

Medical professionals interested in helping shape the future of health care should send CV to Human Resources, fax (612) 829-3664 or call 829-3540 for more information: Health Risk Management, 8000 West 78th Street, M.S. 8-210, Minneapolis, MN 55439. EOE.

HRM[®]

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.

3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Lasers in Urology

Eduardo T. Fernandes, M.D., Paul Gleich, M.D., and Cesar Ercole, M.D.

ABSTRACT

Laser therapy has many applications in the treatment of urologic diseases. The advantages of laser treatment over conventional techniques are less bleeding and pain and a reduced need for anesthesia. The development of new fibers and right-angle delivery systems allows new applications for laser therapy. We review the current indications, advantages, and disadvantages of using lasers for the management of the various urogenital lesions.

The use of lasers for the treatment of urologic disorders is attractive, particularly for patients who are old and at a high surgical risk, because the need for general anesthesia and the risk of bleeding are minimized. Currently, lasers are most commonly used for treating lesions of the skin, relieving strictures, and destroying stones; less commonly, lasers are used for treating superficial urothelial cancer and benign prostatic hyperplasia in selected patients. As we gain more experience with laser therapy, the indications, advantages, and disadvantages of the method are being better defined.

The role of laser (light amplification by stimulated emission of radiation) therapy is increasing in a number of medical and surgical specialties. The basic laser consists of an energy pump, most commonly a flash lamp, which bombards an active medium with photons. This medium (for example, neodymium) then generates monochromatic light that enters a resonator cavity consisting of a very efficient system of mirrors with a center hole in one side where the light is allowed to escape. The laser beam that comes from this resonator cavity is monochromatic, has coherence (all waveforms are in one phase), and is collimated (has a very small angle of diversion).

Most medical lasers work by thermal energy, either causing coagulation of the tissue or raising the temperature significantly above 100°C to create carbonization and vaporization.^{1,2} We use these lasers to burn or remove tumors, to cut scars, and to ablate hyperplastic tissue.^{3,4}

Other medical lasers work by creating intermittent high peaks of energy on a small area and are useful in breaking up stones in the urinary

tract.⁵ Finally, lasers can be used in reconstructive surgery to create sutureless anastomoses. We use this device for laser-assisted vasovasostomy.⁶

The most commonly used urologic thermal lasers are the carbon-dioxide laser (CO₂), the neodymium:yttrium-aluminum-garnet laser (Nd:YAG) and the potassium-titanyl-phosphate laser (KTP). The basic difference between these lasers is the wavelength, which causes tissue interactions and, consequently, determines therapeutic applications. For example, the CO₂ laser, which has very low penetration and produces superficial tissue vaporization, is frequently used for treating external condylomata.⁷ The beam cannot be delivered through our current optics, which limits its use in internal lesions. The Nd:YAG, the most frequently used urologic laser, has good penetration into the tissue and good coagulation capability. It can be delivered through an endoscope and has a wide range of applications, including ablation of superficial bladder and penile tumors, urethral condylomata and strictures, and, most recently, the prostate in patients with benign prostatic hyperplasia.^{1,7-11} The KTP laser is a variant of the Nd:YAG, with a double wavelength that increases its cutting capability, making it ideal for treating urethral strictures and bladder neck contractures.¹² Also, the laser beam is absorbed preferentially by pigments such as melanin and hemoglobin and, therefore, is frequently used for the management of pigmented lesions of the urogenital tract.^{2,7}

Lasers used for breaking stones are the pulsed-dye laser, with coumarin green dye as the resonator; the alexandrite laser; and the Nd:YAG pulse laser. These lasers produce

pulses of high energy and low heat to break the stones, while causing little injury to the surrounding tissue.^{1,5}

CLINICAL APPLICATIONS

PEDIATRIC UROLOGY

The development of small fiber optics and flexible fibers to deliver laser energy allows this energy to be used to manage many pediatric problems. Currently, in this group of patients, lasers are most commonly applied to ablate posterior urethral valves and bladder hemangiomas, relieve urethral strictures, destroy urinary stones, and treat condylomata acuminata.¹³⁻¹⁸ The advantages of laser therapy over conventional electrocautery for the treatment of posterior urethral valves and urethral strictures are the greater precision in tissue ablation and less heating of the surrounding tissue, thereby reducing damage, fibrosis, and the likelihood of secondary stricture formation. In urethral strictures, an 83% success rate has been recently reported in children who previously failed cold urethrotomy or serial urethral dilations.¹⁷ Another potential pediatric indication is laser-assisted tissue welding for hypospadias surgery.¹⁶

URETER AND RENAL PELVIS

The current applications for laser therapy in the ureter and renal pelvis are stone disease and tumor ablation.

The majority of upper urinary tract stones are treated with extracorporeal shock wave lithotripsy (ESWL). However, large staghorn stones, some caliceal stones, hard stones such as cystine, and lower ureteral stones frequently require other types of treatment. In these situations, laser therapy through either the ureteroscope or a percutaneous nephrostomy tract has proved to be efficacious and of great benefit to the patient.^{1,5,19,20}

Lasers can also be used for special cases of transitional cell carcinoma (TCC) of the ureter and renal pelvis.^{21,22} Although nephroureterectomy is the standard treatment of upper urinary tract TCC, less aggressive therapy is indicated for superficial and small tumors in patients with bilateral lesions, chronic renal

failure, or single kidneys. Lesions that can be managed by the Nd:YAG laser are small (less than 1.5 cm), papillary, noninvasive, and of low grade.^{1,9}

BLADDER

The bladder lesion most frequently managed by laser (Nd:YAG) therapy is superficial TCC.⁹⁻¹¹ The advantage of using lasers for this indication is the lesser bleeding and pain and the low incidence of local recurrence (2% to 8% vs. 60% with electrocautery).⁹ The disadvantage is that the burned tissue may not allow adequate pathologic study. A peculiar complication of laser treatment for bladder lesions is bowel perforation, which occurs in 0.01% of cases.⁹ Laser therapy is not indicated for the management of invasive bladder tumors except for temporary palliation in patients who are too sick and debilitated to tolerate standard surgery or chemotherapy.

Carcinoma in situ (CIS) is usually a diffuse lesion that cannot be located precisely for surgical or laser therapy. Therefore, it has traditionally been managed with intravesical chemotherapy (BCG, thiotepa, or, more recently, interferon). A new modality called photodynamic treatment may be beneficial. The patient is given hematoporphyrin derivative (HpD), which concentrates preferentially in tumor cells. Applications of laser light to HpD produce a highly reactive oxygen (singlet-state oxygen) that destroys cellular structures. The results of the treatment of CIS with this technique have been very good, with almost 80% complete remission after previously failed conservative treatment.^{9,23,24}

Bladder neck contractures, particularly those occurring after radical prostatectomies, can also be treated with lasers (KTP or contact Nd:YAG).²⁵ Physicians who advocate the use of lasers over electrocautery for the treatment of this problem believe that the thickness of the cut is better controlled with the laser, and the risk of secondary urinary incontinence is decreased.

Bladder hemangiomas are good indications for therapy with either the Nd:YAG or the KTP lasers.²⁶ Other rare indications are endometri-

osis of the urinary tract and interstitial cystitis. When patients with endometriosis need laser treatment, it is usually delivered through the laparoscope. Occasionally, however, women with endometriosis have bladder lesions that require the laser treatment to be delivered through the cystoscope. Lasers also have been used for the management of interstitial cystitis, although this approach is controversial. Reportedly, patients with more severe pain, particularly if they have Hunner ulcers on cystoscopic examination, may benefit from this treatment.^{1,25}

URETHRA

Urethral caruncles are benign polypoid lesions commonly seen in elderly women. Recently, the Nd:YAG laser has been used because it allows complete photoirradiation of the lesion without causing foreshortening of the urethra and with no postoperative bleeding.⁷

Laser treatment with the Nd:YAG is currently the first choice for urethral condylomata.²⁷ Also, the management of urethral strictures with KTP or Nd:YAG lasers is gaining popularity because the precise cut and low penetration of the laser decrease the likelihood of secondary scar and stricture formation.^{1,8,12,17} However, most urologists still prefer to treat urethral strictures with the electrocautery and the cold knife because of their simplicity and good results.

EXTERNAL GENITALIA

The most common application of laser therapy for external genital lesions is for treating condylomata acuminata, which result from infection with human papillomaviruses. In general, these lesions are ablated with the CO₂ laser, but because recent studies have found active virus in the plume of vaporized tissue created by this laser,²⁸⁻³⁰ many urologists now prefer to manage this lesion with the Nd:YAG laser. Such treatment can be performed under iced water, eliminating smoke containing viral particles.^{1,7}

Superficial penile cancers have been treated with the Nd:YAG laser, with the advantage of avoiding penec-

tomy, but the results are still preliminary.⁷ The best indication for laser therapy in penile carcinoma appears to be for managing premalignant lesions (CIS, Bowen disease, erythroplasia of Queyrat) and balanitis xerotica obliterans. Pigmented lesions, such as hemangiomas, verrucae, and melanomas, and other lesions of high melanin content are best managed with the argon or KTP lasers because the energy is preferentially absorbed by chromogens, such as melanin and hemoglobin.³¹

PROSTATE

A diversity of surgical and medical therapies is now available or under investigation for the treatment of benign prostatic hyperplasia. Surgery, open or endoscopic, is still the cornerstone of the treatment, but the morbidity and mortality of surgical therapy, particularly for the high-risk patient, have prompted the search for less aggressive alternatives. One such treatment is laser ablation of the prostatic tissue, which can be done with ultrasound guidance (TULIP: transurethral laser-induced prostatectomy) or, since the development of new side-firing laser fibers, under direct cystoscopic vision.^{3,4,32,33} The initial reports of TULIP and direct-vision prostatectomy are encouraging, but this technique has some disadvantages when compared with standard transurethral resection.^{33,34}

The advantages of laser prostatectomy are the reduced need for anesthesia (minimal sedation or a local block is all that is required) and the significant decrease in blood loss, allowing patients receiving anticoagulants to be treated without stopping the medication.^{35,36} Laser prostatectomy can be done on an outpatient basis or with a very short hospital stay, and complications such as retrograde ejaculation and impotence are decreased. However, because the depth of penetration of the laser energy is limited, adequate ablation is not possible for very large prostates. Also, because of the swelling caused by the coagulation and necrosis, the obstruction to the urinary tract may initially be worse, necessitating longer use of bladder drainage by a urethral catheter or a suprapubic tube

than is required after standard endoscopic resection (one week to 10 days versus one to two days). Moreover, laser treatment can cause very bothersome and long-lasting (six weeks or longer) irritative symptoms secondary to the sloughing of the necrotic tissue. Also, the incidence of urethral stricture has been high (9.8%), maybe because of the large size of the equipment that was used for the treatment.⁴ Currently, therefore, laser treatment of benign hyperplasia is best indicated for patients who are advised not to use anesthesia, who are more susceptible to bleeding or are on anticoagulants, or who are young, have a smaller gland, and want to retain antegrade ejaculation and potency.

Another potential indication is the treatment of carcinoma of the prostate. Although the results are promising, long-term results are not available to draw sound conclusions, and we still recommend the classic therapy.³⁷⁻³⁹

SAFETY PRECAUTIONS

The potential for eye injury when lasers are in use cannot be overemphasized, and appropriate eye protection is necessary at all times for everybody involved in the procedure, including the patient. Lasers should be used only by authorized and well-trained personnel, who must observe equipment and electrical hazard measures. Special care with smoke products is necessary because active human papillomavirus and HIV have been identified in the plume (smoke) produced by the CO₂ laser vaporization of tissues.²⁸⁻³⁰ If this type of laser is to be used, special masks are required to prevent viral contamination. When proper precautions and documentation are ensured, lasers can be used safely.

FINAL CONSIDERATIONS

The use of lasers in medicine is relatively new, and long-term results are not available for some of the currently used techniques. Still, much progress has been made over the last few years, and more precise indications are beginning to be defined. There is no question that laser therapy offers advantages in some special

situations, and as physicians, our role is to decide what are the best indications, and when, how, and to whom the method should be applied. **MM**

Eduardo Fernandes is a resident with the Department of Urologic Surgery at the University of Minnesota, Minneapolis. Cesar Ercole and Paul Gleich are urologists at St. Paul-Ramsey Medical Center and assistant professors of urology at the University of Minnesota, Minneapolis.

REFERENCES

1. Milam DF, Smith JA. Lasers in urologic surgery—current status. I. AUA Update Series 1994;13:117-24.
2. Stein BS. Laser-tissue interaction. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:10-25.
3. Milam DF, Smith JA Jr. Lasers in urologic surgery—current status. II. AUA Update Series 1994;13:125-32.
4. Childs SJ, ed. Laser-assisted transurethral resection of the prostate (TURP). Baltimore: Williams & Wilkins, 1993.
5. Watson G. Principles of laser stone destruction. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:183-9.
6. Shamberg A, Tansey L, Baghdassarian R, et al. Laser-assisted vasectomy reversal: experience in 32 patients. J Urol 1990; 143:528-30.
7. Malloy TR. External genitalia. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:32-43.
8. Merkle W. Urethra. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:44-55.
9. Hofstetter A, Kriegmair M, Baumgartner R. Evaluation of laser treatment of bladder cancer. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:114-26.
10. Fleischman J, Goldberg G. Management of superficial transitional cell carcinoma of the bladder. Semin Urol 1993;11:193-204.
11. Hofstetter AG. Application of lasers in bladder cancer. Semin Surg Oncol 1992; 8:214-6.
12. Shanberg A, Baghdassarian R, Tansey L, et al. KTP 532 laser in the treatment of urethral strictures. Urology 1988;23:517-20.
13. Brock JW III. Lasers in pediatric urology. In: Smith JA Jr, Stein BS, Benson RC, eds. Lasers in urologic surgery. 3rd ed. St. Louis: Mosby-Year Book, 1994:268-5.
14. Merguerian PA, Seremetis G. Laser-

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

assisted partial nephrectomy in children. *J Pediatr Surg* 1994;29:934-6.

15. Radke M, Waldschmidt J, Stolpe HJ, et al. Blue rubber-bleb-nevus syndrome with predominant urinary bladder hemangiomas. *Eur J Pediatr Surg* 1993;3:313-6.

16. Merguerian PA, Seremetis G, Becher MW. Hypospadias repair using laser welding of ventral skin flaps in rabbits: comparison with sutured repair. *J Urol* 1992;148:667-70.

17. Faerber GJ, Park JM, Bloom DA. Treatment of pediatric urethral stricture disease with neodymium:yttrium-aluminum-garnet laser. *Urology* 1994;44:264-7.

18. Kennedy WA II, Hensle TW, Giella J, et al. Potassium thiophosphate laser treatment of genitourinary hemangioma in the pediatric population. *J Urol* 1993;150:950-2.

19. Krarup VJ, Walter S. Pulsed dye laser treatment of ureteral calculi. *Scand J Urol Nephrol Suppl* 1991;138:31-3.

20. Dretler SP. Urolithiasis-electrohydraulic and laser lithotripsy [Review]. *J Endourol* 1993;7:387-8.

21. Smith AD, Orihuela E, Crowley AR. Percutaneous management of renal pelvic tumors: a treatment option in selected cases. *J Urol* 1987;137:852-6.

22. Schmeller NT. Ureteroscopic applications. In: Smith JA Jr, Stein BS, Benson

RC, eds. *Lasers in urologic surgery*. 3rd ed. St. Louis: Mosby-Year Book, 1994:146-56.

23. Nseyo UO. Photodynamic therapy. *Urol Clin North Am* 1992;19:591-9.

24. Manyak MJ. Photodynamic therapy: principles and urologic applications. *Semin Urol* 1991;9:192-202.

25. Dunshee C, Shanberg AM. Benign diseases of the bladder. In: Smith JA Jr, Stein BS, Benson RC, eds. *Lasers in urologic surgery*. 3rd ed. St. Louis: Mosby-Year Book, 1994:102-13.

26. Vicente J, Salvador J. Neodymium:YAG laser treatment of bladder hemangioma. *Urology* 1990;36:305-8.

27. Volz LR, Carpinello VL, Malloy TR. Laser treatment of urethral condyloma: a five-year experience. *Urology* 1994;43:81-3.

28. Baggish MS, Poisz BJ, Joret D, et al. Presence of human immunodeficiency virus DNA in laser smoke. *Lasers Surg Med* 1991;11:197-203.

29. Garden JM, O'Banion MK, Shelnitz LS, et al. Papillomavirus in the vapor of carbon dioxide laser-treated verrucae. *JAMA* 1988;259:199-202.

30. Hallmo P, Naess O. Laryngeal papillomatosis with human papillomavirus DNA contracted by a laser surgeon. *Eur Arch Otorhinolaryngol* 1991;248:425-7.

31. Jimenez-Cruz JF, Osca JM. Laser treatment of glans penis hemangioma. *Eur Urol* 1993;24:81-3.

32. Smith JA Jr. Benign prostatic hyperrophy. In: Smith JA Jr, Stein BS, Benson RC, eds. *Lasers in urologic surgery*. 3rd ed. St. Louis, Mosby-Year Book, 1994:83-101.

33. Kabalin JN. Laser prostatectomy performed with a right angle firing neodymium:YAG laser fiber at 40 watts power setting. *J Urol* 1993;150:95-9.

34. Kabalin JN. Transurethral laser prostatectomy. *Infect Urol* 1994;7:71-84.

35. Costello AJ. Management of benign prostatic hyperplasia by transurethral laser ablation in patients treated with warfarin anticoagulation. *J Urol* 1994;151:79-81.

36. Kabalin JN, Gill HS. Urolase laser prostatectomy in patients with warfarin anticoagulation: a safe treatment alternative for bladder outlet obstruction. *Urology* 1993;42:738-40.

37. Samdal F, Brevik B. Laser combined with TURP in the treatment of localized prostatic cancer. *Scand J Urol Nephrol* 1990;24:175-7.

38. Amin Z, Lees WR, Bown SG. Technical note: interstitial laser photocoagulation of the treatment of prostatic cancer. *Br J Radiol* 1993;66:1044-7.

39. Beisland HO, Sander S. Localized prostate carcinoma treated with TUR and neodymium:YAG laser irradiation. *Scand J Urol Nephrol Suppl* 1991;138:117-9.

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.

Employee Benefits Attorneys
2600 Eagan Woods Drive, #450
Eagan, MN 55121-1152

Practice limited to ERISA since 1988

Tel: 612-452-9322

Fax: 612-452-9355

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 270 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice
- OB/GYN
- Urgent Care
- ENT - Bemidji
- Pediatrics - Bemidji
- Orthopaedics - Detroit Lakes, Bemidji



For more information contact:
Kathleen McKittrick Toft,
 Director, Physician Recruitment
1-800-437-4010

 **MeritCare Medical Group**
 737 Broadway • Fargo, ND 58123



URGENT CARE OPPORTUNITIES Group Health, Inc.

Group Health, Inc. is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24 hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, or 1-800-472-4695, or send CV to: **Group Health, Inc.,** Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

 **GROUP
 HEALTH
 INC.®**

*Group Health is part of the
 HealthPartners family of health plans.*

EO/AA Employer


HealthPartners

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469



THUNDERBIRD AVIATION

FAA 141 APPROVED FLIGHT SCHOOL

GROUND & FLIGHT TRAINING FOR PRIVATE

• **INSTRUMENT • COMMERCIAL • MULTIENGINE**
• **ATP • FLIGHT INSTRUCTOR**



**OVER 30 YEARS
EXPERIENCE**

**AREA'S LARGEST FLEET
OF PIPER AIRCRAFT**

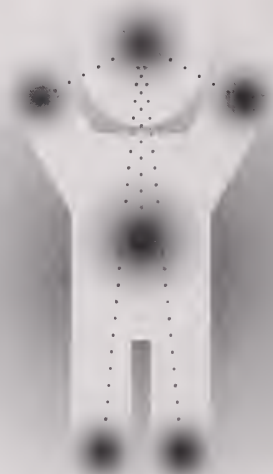
**RENTAL - AIR CHARTER
AIRCRAFT SALES,
MAINTENANCE & FUEL SERVICE**

941-1212

LEARN TO FLY

FLYING CLOUD AIRPORT, EDEN PRAIRIE

CHRONIC PAIN



When the pain won't stop, turn to the **Chronic Pain** program at Gillette Children's Hospital.

The first chronic pain program for children in the region addresses headache, abdominal and musculoskeletal pain, pain associated with trauma, phantom pain, and pain secondary to serious illness.

The comprehensive treatment plan focuses on intervention, pain reduction and stress management.

Treatment options include:

- exercise
- nerve stimulation (as needed)
- hydrotherapy
- self hypnosis
- biofeedback
- massage
- systemic muscle relaxation training
- diversional activities

To refer a patient to the **Chronic Pain** program at Gillette Children's Hospital, call **229-3845**.

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

Physician Employment Agreements— What to Look For

Negotiating a favorable agreement with a new employer is crucial in this age of shifting health care affiliations. Here's what you should consider.

James B. Platt, J.D.

One of the most important legal documents physicians sign today is their employment agreement. In the past, physicians were fairly certain that their practice group would operate for years without a great deal of change. But over the last few years, medical groups have been forming mergers and networks with other groups, and many have been sold to larger organizations. Physicians also have more choices, both in terms of the ownership and governance of the practice with which they affiliate, as well as the type of practice and its relationship with third-party payers. In this time of change and uncertainty, the employment agreement becomes crucial because it often is the only legal document between physicians and their employers. Once the agreement is signed, physicians may not have as much leverage to negotiate changes, particularly if the agreement includes a covenant not to compete. For these reasons, physicians should read their employment agreements carefully and consult with an attorney before signing. Following are some of the potential trouble spots to watch for in an employment agreement.

What Will Be Your Duties?

Most employment agreements describe physicians' duties to the organization in very broad terms. Physicians should attempt to clarify what their duties will be and what criteria will be used to judge their performance.

To Whom Will You Report?

An employment agreement typically requires physicians to devote their "best efforts" to the organization. This means that the physicians must do the best job they can in performing their duties. In private practice, the physicians who own the practice usually set these rules and standards. Physicians generally understand that their obligation is to their practice and fellow partners. But in larger organizations, the lines of authority may be less clear. Physicians may be supervised by a medical director or physician committee for some parts of their practice and by a different person or committee for others. The Internal Revenue Service requires that most tax-exempt organizations be controlled by a board of trustees or directors with no more than 20 percent physician representation.

Because most employment agreements will not specifically define who acts for the employer, physicians should ask how the management of the organization is structured and who will be responsible for assigning physicians their various duties and reviewing their performance under the agreement. Although most integrated organizations promote teamwork and consensus building, physicians who become employees are legally obligated to perform their duties in the manner directed by their employer.

When Will You Work?

Employment agreements usually re-

quire physicians to devote their "full-time and best efforts" to the organization's business. Full time may mean different things to different organizations. The agreement should spell out how many patient contact hours are expected of the physician each week and whether these hours include hospital rounds and nursing home visits. Call coverage, as well as evening and weekend hours, should also be defined.

Where Will You Work?

As integrated systems develop, some clinic locations may be closed or downsized, and physicians may be asked to move to other sites. Physicians may also be asked to work at more than one office, which may make it more difficult to achieve certain production or performance goals. Physicians should request that the agreement specify the location or locations where they will work, as opposed to simply stating that they agree to work "at such locations as the employer may direct."

How Will You Be Paid?

Health care organizations use a wide variety of compensation arrangements. Most organizations have a compensation system that establishes a base salary with some opportunity for bonuses. Bonuses might be based on production or patient visits, up to some limit. In anticipation of increased capitation, some organizations are considering less objective criteria, such as teamwork, patient

outcomes, and satisfaction surveys.

Compensation systems also are changing as a result of increasing government regulation. Tax-exempt organizations, for example, are required under tax laws to ensure that the amounts paid to physicians are "reasonable" in light of the services provided. In addition, the compensation formula itself may not distribute any portion of the net income or profit of the organization to physicians. Stark II also has affected physician compensation formulas. Under the law, physicians can no longer receive a direct percentage of their ancillary service referrals, such as for laboratory and x-ray services.

Physicians should carefully review their proposed compensation arrangement so that they have a good understanding of how the salary and incentives will work. Rather than leave compensation open, the formula and incentives should be spelled out in the agreement.

What About Benefits?

Physicians should not overlook employee benefits, an important part of any compensation package. In particular, physicians should compare their current retirement plan with the retirement benefits offered by the new employer. Physicians may need professional advice to understand the differences, particularly when comparing the benefits provided by different types of plans, for example, between a profit-sharing plan and a defined benefits plan. Physicians should also consider what contributions their new employer will make to the plan in addition to their base salary, and whether those contributions will be "vested" if the physician leaves.

Other benefits, such as health, life, and disability insurance, are important, as well as time off for vacation and attendance at continuing medical education conferences. Most integrated organizations will also pay for hospital dues, DEA license, medical society dues, and other professional activities, up to some cap. These benefits are often not specifically spelled out in the employment agreement but can be incorporated as a separate attachment.

Who Will Pay the Malpractice 'Tail'?

Some self-insured integrated organizations will cover the cost of purchasing a malpractice tail when the physician terminates employment. This coverage is important for physicians who want protection against any claims that might later arise re-

"Physicians should attempt to clarify what their duties will be and what criteria will be used to judge their performance."

lated to their work for the organization. A few organizations will pay a portion of the cost of the malpractice tail based on the number of years the physician is employed by the organization. These policies should be set forth in the employment agreement.

Who Can Terminate the Agreement?

One of the most important parts of an employment agreement deals with the rights of the organization and the physician to terminate employment. Physicians and their attorneys should carefully review the events that would allow the organization to terminate the physician's employment for "cause." Some agreements give the physician an opportunity to remedy any performance problems after reasonable notice by the organization. As organizations increasingly assess physicians based on quality, physicians need to ensure that their agreement entitles them to a measure of "due process" if the data indicate that the physician is not measuring up.

An employment agreement also may permit either party to terminate employment without cause by giving

some advance period of notice, such as 90 days. These provisions can cut both ways; they allow physicians to leave the organization early if the relationship is not working, but they also permit the organization to terminate the physician's employment without showing cause for doing so.

Is There a Noncompete?

Many organizations are including a noncompete covenant in their employment agreements. These covenants are important to consider, particularly in our fast-changing health care marketplace. From the organization's standpoint, a noncompete is a way to protect its investment in developing a primary care base. But for physicians, a noncompete may prevent them from practicing in the geographic area of the organization and may make it difficult for other organizations to employ them.

There are different types of noncompetes. Most restrict the physician from practicing medicine for a year or so within a certain radius of the office where the physician was practicing at the time of termination. Others allow the physician to practice but impose a financial penalty for doing so.

Another key point is whether the noncompete can be triggered regardless of the reason for termination. Some noncompetes are invoked only if the physician terminates employment (as opposed to the organization terminating the physician).

Finally, if a physician has signed a noncompete and wishes to leave the organization and go to work for another practice, the physician should consult with an attorney before doing so, since the enforceability of a noncompete often depends on the particular facts at the time of termination.

Other Rights and Obligations

Apart from the terms of the employment agreement, physician employees have other obligations and rights created by state and federal law. For example, physicians are entitled to take time off for maternity or pater-

nity leave and to continue health and life insurance coverage for a period of time after termination, at their own expense. They are entitled to be treated fairly and not to be discriminated against on account of, among other reasons, race, religion, age, or disability. Minnesota law also has special provisions regarding the rights to patents and inventions. Similarly, state and federal laws impose certain obligations on physician employees, such as the duty of loyalty to the organization.

Conclusion

As physicians consider whether to become employees, they need to be sure they understand the terms of their employment agreement and what their future employment relationship will be with the new organization.

MM

James Platt is a shareholder and officer of Fredrikson & Byron, P.A., and co-chair of its Health Law Practice Group in Minneapolis.



Family Practice

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 155 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care - at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

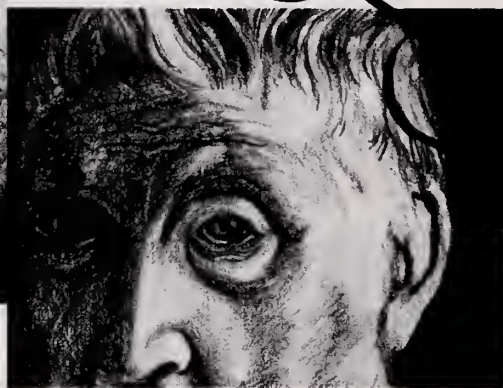
623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183



A COMMITMENT TO
Quality

STARTS WITH

Quality Peer Review

The Minnesota Medical Association is proud to announce its Peer Review Consultation service. This program, tailored to meet state and federal guidelines, is designed for use by hospitals, clinics and other organizations that need peer review by an impartial third party.

Reviewing physicians

- ◆ are either board certified or eligible in appropriate specialties or subspecialties
- ◆ have been trained in objective peer review procedures
- ◆ will conduct reviews on-site or off
- ◆ will provide an advisory report containing background information, findings of fact and conclusions

To obtain confidential peer review consultation services, call the MMA and ask for Peer Review Consultation Services. In the Twin Cities call 378-1875. Outside the metro area call toll free, 1-800-999-1875.

The MMA is committed to helping you maintain and improve the quality of health care.

Call us today.



MMA

Minnesota Medical Association

ANNOUNCEMENTS

.....

MMA RESOLUTIONS ARE DUE JULY 21

Resolutions to the 1995 Minnesota Medical Association House of Delegates should be submitted to the MMA office by Friday, July 21, 1995, to allow sufficient time for reproduction and distribution to the delegates. The 142nd MMA Annual Meeting will be held at the Kahler Hotel in Rochester, September 27-29, 1995. The House of Delegates will be in session on Thursday, September 28, and Friday, September 29.

...

NOMINATIONS ARE OPEN

If you are interested in running for election as an MMA officer, or if you would like to nominate another MMA member, contact your representative on the Nominating Committee. Elections for the MMA offices of president-elect, vice president, secretary, treasurer, speaker of the MMA House of Delegates, and vice speaker of the House will be held at the 1995 MMA Annual Meeting in Rochester, September 27, 28, and 29.

The members of the nominating committee are: C. Randall Nelms, M.D., chair; John Balfanz, M.D. (East Metro); Nicholas Bernier, M.D. (North Central); Penny Langland, M.D. (Northwest); Daniel Maddox, M.D. (Southeast); Robert Meiches, M.D. (West Metro); Lyle Munneke, M.D. (Southwest); and Ben Owens, M.D. (Northeast).

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Launches Campaign Against Media Violence

The Minnesota Medical Association, at a news conference June 6 launched a major public health campaign to make parents aware of the harm that violent television programs, movies, and video games cause to children.

"Violence has become a public health epidemic," MMA president Andrew J.K. Smith, M.D., told reporters. "Among our young people 15 to 24 years old, homicide is the second leading cause of death, and for African-American youth it is No. 1." To treat this epidemic, the MMA is asking family physicians, pediatricians, and other health care providers to talk to young patients and their parents about violence in the media. "During routine patient screening, we physicians have an opportunity to urge parents to limit the amount and kind of programs their children watch," Smith said.

The scientific evidence linking violent programming and violent behavior is overwhelming, according to David Walsh, Ph.D., a psychologist at Fairview Behavioral Services. Research by the National Institute of Mental Health and by other experts shows clear evidence that children exposed to high levels of media violence are much more likely to be aggressive, to exhibit violent behavior, and to see violence as an effective way to resolve conflicts. Calling television the "new electronic teacher," Walsh told reporters that children learn by copying the behavior they see. By the time most young people graduate from high school, they have witnessed

more than 200,000 acts of media violence. "We don't need more studies, we need action," Walsh said.

The MMA is taking action. To help start the conversation on media violence, the MMA has mailed posters, buttons, bumper stickers, and a brochure called "10 Tips for Parents to Stop the Media Violence," to about 400 pediatricians and family practice physicians. The association has also produced radio and television public service announcements featuring Bob Keeshan, who played Captain Kangaroo on television.

AG Cheers On MMA

At the news conference, Attorney General Hubert Humphrey III congratulated the MMA for coming to grips with the disease of violence. "Doctors know violence is a disease that can't be isolated in prisons or in certain neighborhoods, and if it's not stopped, it will infect every one of us. We can treat one of the germs causing this disease by stopping the flood of violence that children watch day in and day out." Humphrey praised the MMA for trying to educate parents rather than blaming the media or calling for censorship.

The topic of media violence will receive national attention this summer when Humphrey and Smith lead a delegation of Minnesota business, religious, and media leaders to Vice President Al Gore's conference, "Family Reunion for the Family and Media," July 9-10 in Tennessee.

Joining the MMA at the news conference were Molly Koivumaki,

Violence continued on page 34

Violence continued from page 33

representing Minnesota Turn Off the Violence, and Glorius Martin, producer of the KTCA-TV program, "Don't Believe the Hype." Turn Off the Violence is a grass-roots coalition committed to creating a nonviolent society. The MMA will join the coalition in promoting Turn Off the Violence Day, October 12, a day when people will be asked to turn off violent entertainment and choose nonviolent ways of resolving conflicts. "Don't Believe the Hype," a program aimed at people of color, has focused on ways to resolve problems without resorting to violence. Martin told reporters that "Don't Believe the Hype" also features rap videos that aren't violent enough to make it on commercial television.

The media response to the MMA campaign was enthusiastic. The story was covered by KTCA-TV's "Almanac," WCCO-TV, KMSP-TV, KSTP-TV, KARE-11 TV, and by many radio stations and newspapers throughout the state. Articles by Gordon Slovut and by Jim Klobuchar appeared in the Minneapolis-based *Star Tribune*.

If you would like to receive bumper stickers, buttons, copies of "10 Tips for Parents to Stop the Media Violence," or posters to display in your office, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875. •••••

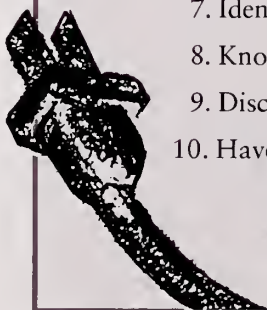
In Brief Will be Back Next Year

The Minnesota Medical Association publishes *The Monitor in Brief* from January through June to keep members up-to-date during the legislative session. You will receive your next issue in mid-January 1996.

10

Tips for parents to stop the media violence

1. Set clear limits.
2. Don't use the TV as a babysitter.
3. Don't make TV the focal point in your home.
4. Offer other enjoyable activities.
5. Choose what to watch.
6. Ban unacceptable programs.
7. Identify high-quality programs.
8. Know what your kids are watching.
9. Discuss media violence.
10. Have a voice in local TV programming.



MMA
Minnesota Medical Association
Stop the violence campaign

MMA Leaders Named to Task Force On Violence

Governor Arne Carlson appointed Ged A. Stuart Hanson, M.D., past president of the Minnesota Medical Association, and Andrew J.K. Smith, M.D., current MMA president, to serve on a blue-ribbon task force to study violence as a public health problem and to propose ways in which providers can help prevent and reduce violence.

Hanson received the "Stop the Violence" award at the 1994 MMA Annual Meeting. During his term as president, he was a leading force in launching the MMA campaign against domestic violence and abuse. Smith, a strong voice in the current MMA campaign against media violence, will join Attorney General

Hubert Humphrey III in leading a delegation of community leaders to Vice President Al Gore's conference on violence July 9-10 in Tennessee.

One specific charge of the governor's task force is to measure the impact of violence on the health care systems in Minnesota. The 12-member task force will also examine the principal causes of violent behavior, review existing and proposed interventions, and propose cooperative and unified public-private partnerships to enhance prevention efforts in communities throughout the state. The task force will report its findings to the governor by January 1, 1996. •••••

ANNOUNCEMENTS

• • • • •

MMBR INTRODUCES NEW MEMBER SERVICES

Minnesota Medical Business Resources (MMBR) has recently introduced two new services for MMA members.

WorldPerks Visa Card

Minnesota Medical Association and Minnesota Medical Group Management Association members and spouses can earn 3,000 WorldPerks Bonus miles on Northwest Airlines when they apply to become a First Bank WorldPerks Visa card member. By using the WorldPerks Visa card, members earn one mile for every dollar they spend on purchases. To apply, call 612/623-2860 or 800/298-MMBR (6627).

Investment Advisors

In addition, MMBR has entered a partnership with AMA Investment Advisors that will enable it to provide high-quality financial products and services to MMA members. Free financial planning seminars will provide objective information on investments. Consultations with a personal financial counselor will help members identify a financial strategy tailored to their current situation as well as their long-term objectives. Watch for more information on this valuable new MMBR service.

• • •

MMA SELLS BUILDING

University Office Plaza, which was partially owned by the Minnesota Medical Association, has been sold. Since 1984, the MMA had owned the building with three other partners, the Hennepin Medical Society, the Minnesota Hospital Association, and the American Academy of Neurology. MMA offices were located in the University Office Plaza until December 1993, when the association moved to its present location.

Research Links Media Violence to Real Violence

The evidence is "conclusive and overwhelming" that watching media violence makes children behave more aggressively, according to David Walsh, Ph.D., author of "Selling Out America's Children" and of an editorial on TV violence in the June issue of *Minnesota Medicine*. This is not surprising, Walsh said, since we know that children learn by watching and imitating adult behavior.

Consensus of the Experts

After 10 years of research, a report by the National Institute of Mental Health concluded: "The consensus among the research community is that violence on television does lead to aggressive behavior by children and teenagers who watch the programs." Reports by the U.S. Surgeon General, the National Institute of Mental Health, the American Psychological Association, the Centers for Disease Control and Prevention, the National Academy of Science, and the Society of Adolescent Medicine came to the same conclusion.

Examples of the Research

The following research studies were described in more detail in the October 1994 issue of *Pediatrics*.

- Experiments in 1963 by A. Bandura showed that preschoolers learn aggressive behavior by watching television. In one experiment, three groups of children were shown a program in which an actor walks up to a life-size doll and tells it to move away, then attacks the doll, beating it with his fists and then with a mallet. There were three different endings. One group of children saw the actor given candy. The second group saw no reward or punishment, and the third group saw the actor scolded. After watching this

program, children in the first two groups acted aggressively compared with children who had not seen the program or who had seen the actor punished.

- A number of field studies have exposed one group of children to violent programs while allowing a control group to see only non-violent programs. Trained observers watched the children and analyzed their behavior. These studies established a clear link between watching violent programs and aggressive behavior.

- A 22-year study reported by L.R. Huesmann in 1986 found a strong correlation between the amount of televised violence that children watched at age 8 and the number of violent crimes they committed at age 30.

- A population-based study reported by Brandon S. Centerwall, M.D., M.P.H., in 1992 examined the homicide rate trends in Canada, the United States, and South Africa after the introduction of television. The study found that 10 to 15 years after television was introduced in each country, homicide rates more than doubled.

Risk Factors Add Up

Violence in the media is just one of many risk factors for aggressive behavior, including poverty, drugs, racism, and an abusive family or community environment. The accumulation of experiences is important, according to Walsh. "It's like balancing tennis balls—if you give me one, I can handle it, but if you add more and more, it all falls apart."

• • • • •



Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

New Guidelines Help Measure Cost-Effectiveness

In this era of tightening budgets, physicians and health care plans have to stretch the health care dollar as far as possible. We can't afford to spend money on procedures that have little chance of success. Despite its importance, however, cost cannot be the only consideration. We don't want concern for the bottom line to compromise quality of care or to stifle medical innovation.

So how do we find the proper balance? Caught between a rock and a hard place, health care decision-makers try to weigh the costs and benefits of each new drug, device, or medical procedure and to compare it with existing alternatives. Identifying value is crucial.

The most scientific, rational way to identify value is through a cost-effectiveness evaluation, but there has been no agreement within the health care system on the exact meaning of "cost-effectiveness," much less on how to measure it. Some studies focus on cost, ignoring or giving short shrift to health care outcomes. This makes it extremely hard to make useful comparisons of various studies.

Now, however, in the first major effort of its kind, the Medical Alley Cost-Effectiveness Task Force has introduced a report that includes standard definitions and practical guidelines to measure cost-effectiveness. The two-volume publication, "Measuring Cost-Effectiveness: A

Road Map for Health Care Value," will enable health care organizations to make better decisions by following a 12-step process.

The task force, which I chaired, included representatives from a cross-section of Minnesota's health care industry. We worked on this project for more than a year before we reached consensus and issued a document we could all support. Our goal was to establish a standard process, agreed upon by the entire industry. We wanted to make it easier to judge the quality of any cost-effectiveness study, to compare and contrast different technologies, and to evaluate various studies of the same technology.

Significantly, this report defines a technology as having value if it improves outcomes and patient satisfaction, or holds down costs, or both. It assumes that decisions should not merely be cost driven, but should balance benefits and costs.

In developing this report, the task force worked with information that was already available, but known mainly in academic circles, and made it practical, simple, and easy to use. The first volume explains issues and methods; the second volume, a technical manual, outlines the process of cost-effectiveness evaluation.

Our report includes four major recommendations for conducting cost-effectiveness studies:

1. Use a standard framework to

obtain cost-effectiveness information. A checklist form allows the reader to determine whether an evaluation accurately describes the relevant data. This standard framework will make it easier to compare different studies.

2. Fully disclose the methods used to determine costs and outcomes. This information will allow the reader to understand the methods used and also to become aware of possible conflicts of interest or biases.

3. Consider the community perspective when doing a cost-effectiveness evaluation. Consider consequences for the community and for the individual of various alternatives.

4. Use cost-effectiveness information when it is appropriate. An evaluation is not necessary for every new technology. The criteria in the report indicate when an evaluation will be most useful. The task force does not support state or federal regulation of technology assessment. Market forces should drive the provision of cost-effectiveness information.

The task force report will be a valuable tool for physicians. We are on the front lines, treating patients, ordering tests and procedures. We often face tough choices. Our ethical mandate to serve as our patient's advocate may conflict with an added responsibility to care for an entire group of patients within a fixed budget. This publication will help us judge the accuracy and validity of various studies and to take a balanced approach to decision making.

The Medical Alley publication will also be useful to manufacturers, insurers, and researchers. As each new drug device or medical procedure comes into the market, its manufacturer must prove its value to cost-conscious buyers. Will this technology improve health care outcomes, or reduce costs, or both? The report clearly defines the goals of innovation.

We have a long way to go in the emerging field of technology assessment, but this publication will serve as a road map to guide us on the journey toward a more efficient health care system. • • • • •

Medical Alley Releases Health Care Cost-Effectiveness Report

• • • • • MEDICAL ALLEY HAS released "Measuring Cost-Effectiveness: A Road Map for Health Care Value," a report that outlines a standard method for the health care community to use in assessing or demonstrating the value of medical procedures and products. The report was prepared by the Medical Alley Cost-Effectiveness Task Force, chaired by Andrew J.K. Smith, M.D., president of the Minnesota Medical Association. (See facing page for Smith's "Viewpoint" column on the report.)

Checklist for Assessment

The two-volume publication includes a 12-step check list to use when assessing a technology's value.

Foundations of Cost-Effectiveness Evaluation

1. Describe the technology and its potential benefits. Include demographic information and information on appropriate use.

2. State the perspective used to compare costs and benefits.

3. State which technology alternatives are compared.

4. State which analytic tools were used and explain why they were chosen.

Measuring Costs

5. Describe the data sources used for all financial costs included in the evaluation.

6. State whether costs relating to productivity or lost work days (indirect costs) are included and listed separately.

7. If appropriate, break down cost information into a per-member per-month rate for a given population.

Measuring Outcomes

8. Describe the dimensions of health outcomes included in the evaluation.

9. Describe the sources used to gather health outcomes data.

Issues of Time and Uncertainty

10. State the time horizon used to determine costs and outcomes.

11. Describe the discount rate(s) included in the the analysis.

12. Test key assumptions using sensitivity analysis.

For information on how to obtain a copy of the report, or to arrange for a presentation of the Task Force report, call Medical Alley at 612/542-3077.

NATIONAL NEWS

NEW JERSEY COURT ALLOWS PATIENTS TO SUE HMOs

The New Jersey Supreme Court has held that the New Jersey HMO Act permits HMOs to be sued directly by a patient for medical malpractice. It also determined that a physician can assert a cross-claim against an HMO in a malpractice claim for breach of contract based on the HMO's failure to coordinate a patient's care.

HHS SETS UP PILOT PROJECT TO TEST MANAGED CARE

The U.S. Department of Health and Human Services has introduced a pilot project to examine the quality of care of Medicare managed care plans in four states. Peer review organizations in California, Florida, New York, and Pennsylvania will

collect data from 23 managed care organizations to measure overall quality of care using indicators developed by the Delmarva Foundation for Medical Care. If the 18-month pilot program is successful, HHS intends to introduce a similar program throughout the nation.

PHYSICIANS GIVE GENEROUSLY IN CHARITY CARE

More than two-thirds of U.S. physicians are providing over \$21 billion in charity care to needy patients, according to a report by the American Medical Association. The report shows that 307,650 physicians gave \$11.31 billion in charity or reduced-fee care to patients in need during 1994, and they absorbed

an additional \$9.82 billion in bad debts.

Nearly 68 percent of U.S. physicians provided free or reduced-fee care in 1994, up from 62 percent in 1988. Physicians spent 12.4 percent of their work time, one of every 10 hours, on charity care. On average, a physician devoted 7.2 hours per week caring for the poor, an increase from 6.5 hours in 1990.

AMA MEETS

As *The Monitor* goes to press, the American Medical Association is holding its 1995 Annual Meeting in Chicago. The activities of the Minnesota delegation will be reported in the August *Monitor*.

ANNOUNCEMENTS

• • • • •

MEDPAC KICKS OFF ITS MEMBERSHIP DRIVE

MEDPAC, the Political Action Committee of the Minnesota Medical Association, has written to MMA members urging them to join or renew their membership. MEDPAC supports political candidates in Minnesota who support the MMA's legislative goals and recommends national candidates to AMPAC.

"We are approaching a crisis with MEDPAC," according to John Dowdle, M.D., chair of the MEDPAC Board of Directors. "Membership in MEDPAC is at an all-time low, and if it remains at this level, we cannot be active in the crucial 1996 elections." In 1996 the entire Minnesota Legislature, all eight members of Congress, and one of Minnesota's two U.S. Senators are up for re-election.

A sustainer membership in MEDPAC is \$150 and a regular membership is \$75.

• • •

CALL FOR DISCOUNT GOLF TICKETS

Minnesota Medical Association members will receive a 10 percent discount on tickets to the Burnet Senior Classic August 7 to 13. Save \$5 to \$12 off the Ticketmaster prices and walk the course with Arnold Palmer, Chi-Chi Rodriguez, and Lee Trevino. To order, call Jim Fitzgerald at 612/673-8430 and identify yourself as an MMA member. Use a ticket order form or your credit card to place your order.

Individual Ticket Prices

Classic Pass, Monday to Sunday, \$90, \$12.75 off Ticketmaster price;

Championship pass, Friday to Sunday, \$67.50, \$10.25 off Ticketmaster price;

One-day pass, good any day, \$27, \$5.75 off Ticketmaster price.

Physicians May Be Only Hope for Violence Victims

The Minnesota Medical Association's campaign against media violence is part of its ongoing campaign against violence and abuse.

Physicians are in an excellent position to help women escape the cycle of domestic abuse, said Robert E. McAfee, M.D., president of the American Medical Association, and Susan Hadley, founder of Woman-Kind, to the medical staff of St. Joseph's Hospital at a meeting in St. Paul last fall. "When women are asked whom they would rather tell about abuse, 87 percent name their doctor," McAfee said. "We can be better diagnosticians." If a man cancels an appointment a woman has made, there's a 50-50 chance the woman has been battered. McAfee said that at first he was skeptical, but when he started red flagging these cancellations, he found from his own experience that it was true.

McAfee urged physicians to seize the "teachable moment." "If you treat adult women, you had at least one domestic abuse victim in your office in the last two weeks. Who was it? If you don't ask, you won't ever know."

Explaining why domestic violence is a medical issue, McAfee said, "More years of life are lost to violence in our society than years of life lost to heart disease and stroke combined."

Hadley posed the question: "Why do women stay in an abusive relationship? They're adults. Why don't they just walk out the door?" Answering her own question, Hadley explained, "It doesn't start out with a fist to the face. It's much more insidious. It begins with a gradual process of isolation until the woman is separated from her friends and family. Her physician may be the only one she can turn to for help."

Hadley acknowledged the frustration of the person who tries to

intervene and apparently fails. "You can't make anyone do something they're not ready to do," she said. A physician who talks to a woman about domestic violence has succeeded in intervening—even if the victim does nothing. "You have achieved success if you have given support, talked about violence, and helped her consider her options." The victim has heard the message and may be starting her own process. It may take a long time for her to escape the cycle of violence.

Battered women hesitate to talk to anyone about their situation because they're afraid of being judged, or of being forced to take some action they're not ready to take, Hadley said. It's important for them to know that a physician cannot report domestic abuse unless a firearm or a knife was used in the assault.

McAfee also addressed the role that handguns play in violence. "When it's easier to get a handgun than a library card, something's wrong," he said. The AMA seeks a ban on guns that don't meet import standards. McAfee cited the Saturday Night Special, a gun so small it can be concealed in the palm of the hand. This gun could not be imported into the United States but it is made by California companies. At the AMA Interim Meeting in December 1994, the AMA House of Delegates voted to support legislation to restrict the sale and private ownership of the Saturday Night Specials, as well as of the large clip, high-rate-of-fire automatic and semi-automatic firearms. Stressing the need for stronger gun control laws, McAfee said the AMA has pleaded with national leaders, "Don't put a cap on health care spending until you first put a cap on the cause of violence. We physicians are sent the bill."

• • • • •

Community Service Award

The MMA's Community Service Award honors an MMA physician who has an outstanding record of community service. A typical candidate might be a physician who:

- helps make free clinical care available to the needy,
- serves as a public official,
- coaches an athletic team,
- is a leader in promoting cultural or arts activities, or
- is a leader in expanding voluntary health programs.

The Community Service Award will be presented at the MMA Annual Meeting in Rochester on September 28, 1995.

If you know a physician who qualifies for this award, please fill out the attached nomination form and return it to Karen Tourdot, Minnesota Medical Association, Suite 300, Broadway Place East, 3433 Broadway Street NE, Minneapolis, MN 55413-1761.

MINNESOTA MEDICAL ASSOCIATION
PHYSICIAN AWARD FOR COMMUNITY SERVICE
NOMINATION FORM
QUALIFICATIONS

1. The recipient must be a physician member of the Minnesota Medical Association licensed to practice in the state of Minnesota.
2. The recipient must be living. Awards are not presented posthumously.
3. The recipient has compiled an outstanding record of community service which, apart from his or her specific identification as a physician, reflects well on the profession.

NAME OF NOMINEE: _____

(Home Address) (Business Address)

(Home Telephone) (Business Telephone)

Describe why this person should receive the MMA Community Service Award: _____

(Supporting information may be included by attachment.)

NOMINATION SUBMITTED BY:

(Address) (Telephone)

NOMINATIONS DUE ON OR BEFORE JULY 15, 1995.

PUBLIC HEALTH

**MMA HOUSE OF DELEGATES
WILL CONSIDER PUBLIC HEALTH
ISSUES**

The Minnesota Medical Association Board of Trustees has referred several recommendations of the MMA Committee on Public Health and Preventive Medicine to the MMA House of Delegates. The recommendations ask the MMA to take the following actions:

- support the development, implementation, and enforcement of legislation to protect human health while controlling air pollution, and support the position that air quality standards should be established using the best available scientific data;
- support the routine offering of the HIV test to all pregnant women and disseminate information to Minnesota physicians on the prevention of maternal-infant HIV transmission;
- endorse and disseminate the standards for Pediatric Immunization

Practices recommended by the National Vaccine Advisory Committee.

• • • • •

**ENCOURAGE YOUR PATIENTS TO
WEAR HELMETS**

Each year, thousands of Minnesotans suffer brain injuries. Many of these injuries could be prevented by wearing helmets. Call now for a free packet of information to help you promote helmet use by your patients.

Helmets should be standard equipment for many recreational activities.

- Children should always wear helmets when riding their bikes.
- In-line skaters should wear multi-impact helmets or bicycle helmets.
- Riders of all-terrain vehicles and motorcycles should wear motorcycle helmets.
- Snowmobilers usually wear a full-faced helmet.

- Horseback riders, regardless of their experience or riding activity, should wear equestrian helmets.

To obtain a free packet to help you promote helmet safety, write the Minnesota Injury Prevention Program, Minnesota Department of Health, 717 SE Delaware Street, Minneapolis, MN 55440, or call 612/623-5285, or fax 612/623-5775.

• • • • •

**DOCS AND VETS WARN ABOUT
LYME DISEASE**

The Minnesota Medical Association has joined with the Minnesota Veterinary Medical Association to increase public awareness about Lyme disease, a disease that affects both people and animals. The two associations recently issued a joint news release explaining the facts about Lyme disease risk, prevention, and treatment.

Governor Arne Carlson Honors MMA Women Physicians

Doris C. Brooker, M.D., and Jean L. Harris, M.D., were among 22 Minnesota women recognized for their leadership by Gov. Arne Carlson. The awards were presented at the Fifth Annual Governor's Women's Leadership Breakfast May 19 in St. Paul. "The women we are recognizing are wonderful examples of the level of involvement and expertise that so many women bring to our communities and to the workplace," Carlson said. "Their commitment and success serve to encourage and inspire others."

Doris C. Brooker, M.D., is a member of the academic and clinical staffs

at the University of Minnesota, specializing in laboratory medicine, pathology, and obstetrics and gynecology. She is recognized nationally as an expert in the field of women's health.

Jean L. Harris, M.D., is senior associate director and director of medical affairs at the University of Minnesota Hospital and Clinic and is the mayor of Eden Prairie.

Watch for an article on these outstanding women in the August issue of *The Monitor* in *Minnesota Medicine*.

• • • • •

The Monitor

JULY 1995

• • •

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

• • •

Emerging Infectious Diseases: Controversies, Causes, and Control

The dangers of emerging pathogens are real, but they need to be placed in a broader medical and epidemiologic perspective.

Kristine L. MacDonald, M.D., M.P.H., and Michael T. Osterholm, Ph.D., M.P.H.

This issue of *Minnesota Medicine* includes reviews by Editor-in-Chief Dr. Charles Meyer of two books—"The Hot Zone" by Richard Preston and "The Coming Plague: Newly Emerging Diseases in a World Out of Balance" by Laurie Garrett (page 45). Although both books provide insight into the dangers of emerging pathogens, both also need to be placed in the context of a broader medical and epidemiologic perspective. For example, although Ebola virus (the subject of Preston's book) is a recently identified infectious disease with an exceptionally high mortality rate and is alarming for that reason, it is not easily transmitted among humans in the absence of blood contact. An outbreak of Ebola virus infection would not sustain itself in an area where adequate infection control is practiced, such as in the United States. Similarly, some of the examples of emerging pathogens reviewed by Garrett include relatively rare pathogens that, individually, are unlikely to have a considerable impact on human morbidity and mortality in the coming years. However, those of us who work in public health control of infectious diseases believe that the threat posed by emerging pathogens is real. One need only examine a few statistics to recognize the potential impact of this threat as we move into the 21st century:

- Infection with the human immunodeficiency virus (HIV) is the No. 1 cause of death in Americans aged 25 to 44.¹ This disease was unheard of only 14 years ago.

- Each year approximately 2 million patients acquire nosocomial infections in U.S. hospitals. Approximately 60% of these infections involve antibiotic-resistant bacteria.² About 40% of nosocomial *Staphylococcus aureus* infections in the United States are methicillin-resistant (MRSA); vancomycin-resistant enterococci (VRE) have increased 20-fold (up to 14%) since 1987 in U.S. intensive care units.²

- In some communities in this country, penicillin-resistant *Streptococcus pneumoniae* account for more than 25% of community isolates.³

- Globally, more than 1 million people die each year of malaria. Extensive chloroquine resistance has emerged

in the past few years, and resistance to newer anti-malarials is appearing more frequently. Of equal concern is the development of resistance by mosquitoes to once-potent pesticides. This resistance has contributed greatly to the dramatic resurgence of malaria throughout the tropics.⁴

- The reported incidence of dengue hemorrhagic fever/dengue shock syndrome (DHF/DSS) has increased significantly worldwide in the past few years. Between 1980 and 1985, 804,000 cases were reported—more than the total number reported for the previous 25 years.⁴ DHF/DSS occurs in people infected with two or more serotypes of dengue virus. The global spread and mixing of dengue serotypes has led to the recent emergence of this life-threatening complication of a relatively common infectious disease.

The Institute of Medicine's 1992 report "Emerging Infections: Microbial Threats to Health in the United States" defines emerging infectious diseases as "clinically distinct conditions whose incidence in humans has increased [in the past two decades]. ... Emergence, or, more specifically reemergence, may also be used to describe the reappearance of a known disease after a decline in incidence."⁴ The IOM report outlines numerous examples of emerging infections, some of which are outlined in the accompanying table (see page 42). The report also provides insight into the major factors contributing to emergence. These factors are briefly outlined below.

CONTRIBUTORS TO EMERGING INFECTIONS

HUMAN DEMOGRAPHICS AND BEHAVIOR

The rapid growth in worldwide population and a changing population distribution have fostered the emergence of infectious diseases. For example, increasingly large urban centers throughout the developing world contain slums and shanty towns of recently arrived residents from rural areas, a trend that has often resulted in overcrowding and inadequate sanitation.

A growing population of people at risk for opportu-

Table 1

Examples of emerging pathogens

Bacteria	<i>Borrelia burgdorferi</i>
	<i>Compylobacter jejuni</i>
	<i>Chlamydia pneumoniae</i>
	<i>Ehrlichia</i> species
	<i>Escherichia coli</i> O157:H7
	Group A streptococcal organisms
	<i>Helicobacter pylori</i>
Viruses	<i>Neisseria meningitidis</i>
	<i>Salmonella</i> species
	Filoviruses (Marburg, Ebola)
	Hantavirus
	Human immunodeficiency virus, types 1 and 2
	Human papillomavirus
	Human T-cell leukemia virus, types 1 and 2
Parasites	Lassa virus
	Rift Valley fever virus
	<i>Cryptosporidium</i> species
	<i>Giardia lamblia</i>
	Microsporidia
	<i>Plasmodium</i> species
	<i>Pneumocystis carinii</i>

nistic infections has also encouraged the spread of infectious disease. A number of factors have led to greater immunosuppression: an aging population in some areas, such as the United States; immunosuppressive medications for transplantation, therapy of malignancy, or treatment of autoimmune disease; malnutrition; severe trauma or burns; and other concurrent infections (of most recent importance is concurrent HIV infection). Immunosuppression, most notably that associated with HIV infection, has also contributed to the recent increase in tuberculosis (TB) in the United States. As the HIV pandemic moves through Asia, we can expect to see significant increases in the incidence of TB in those populations as well.

Finally, human behavior patterns have promoted infectious disease emergence, as most clearly illustrated by the HIV pandemic. In regions of Africa and Asia, for example, urbanization and resulting changes in sexual behavior have increased the rapid spread of HIV infection across those continents. Sexual behavior and use of intravenous drugs continue to be primary modes of HIV transmission in the United States and elsewhere. Public health efforts over the last 10 years have shown how difficult such behaviors are to change.

TECHNOLOGY AND INDUSTRY

Nosocomial infections have increased dramatically in the United States over the past few years despite vast improvements in infection control. This increase can be attributed in part to technological advances, such as the use of a variety of medical devices (for example, indwelling catheters, endotracheal intubation, and mechanical

ventilation). Complex invasive procedures, such as tissue or organ transplantation, can also lead to nosocomial infections through the use of immunosuppressive drugs.

Changes in food processing and handling have also contributed to the emergence of new infectious diseases or reemergence of well-known foodborne pathogens.^{5,6} Mass production of foods has led to problems with low-level contamination of widely distributed products, as happened with the recent outbreak of *Salmonella enteritidis* associated with consumption of Schwan's ice cream produced in Minnesota.⁷ Based on calculations involving known attack rates in a random sample of Schwan's consumers and data on production and distribution of the product, we estimate that approximately 250,000 cases of salmonellosis occurred in the United States as a result of contamination of this product. This is the largest recognized outbreak of salmonellosis ever identified in this country. Outbreaks associated with consumption of widely distributed products with low-level contamination are being recognized more frequently, despite serious shortcomings in foodborne disease surveillance. Finally, agricultural practices have contributed to the emergence of *Escherichia coli* O157:H7 and *Campylobacter jejuni*, and reemergence of other foodborne pathogens such as *Salmonella* species.

ECONOMIC DEVELOPMENT AND LAND USE

Changes in the environment can alter the ecological balance between arthropod vectors, animal hosts, and humans. Reforestation in the northeastern United States has promoted an increase in the population of the white-tailed deer, which is an important host for the tick vector of Lyme disease; as a result, Lyme disease has rapidly spread through that region. The expansion of hydroelectric and irrigation projects worldwide also has had an impact; for example, the construction of the Aswan Dam in Egypt altered the water table in that area, allowing more mosquito breeding and emergence of Rift Valley Fever (a mosquito-borne viral disease) in the Egyptian population.

INTERNATIONAL TRAVEL AND COMMERCE

Importation of malaria into the southern United States is of concern because of the potential for this pathogen to become endemic based on the presence of appropriate mosquito vectors and climatic conditions. More than 1,000 cases of malaria are imported into the United States each year. Many of these cases are identified in southern states, particularly those that border Mexico. Recently, a cluster of indigenously acquired cases was identified in Houston, Texas, demonstrating the potential for malaria to reestablish itself in this country.⁸

Globalization of the food supply through international commerce has also increased the importation of unusual or exotic pathogens into the United States. Today, up to 70% of fruits and vegetables consumed seasonally here are grown in developing countries. Travelers to these countries would be advised to "boil it, peel it, or don't eat it" because of the risk of traveler's

diarrhea. In this country, consumption of similar products likely leads to such illnesses, but the cause goes largely unrecognized. Several outbreaks of cholera have occurred from consumption of foods imported into the United States from developing countries. Outbreaks of other pathogens, such as enterotoxigenic *E. coli*, resulting from imported products also have occurred.

Reported cases of multidrug-resistant tuberculosis (MDRTB) imported via airline travel into the United States are on the rise. In fact, as airline travel becomes more prevalent and we move to a global community, outbreaks of unusual diseases occurring in remote parts of the world can have a potentially dramatic impact in this country. Recently, for example, an outbreak of plague in India raised concern regarding the potential importation of plague into the United States.

MICROBIAL ADAPTION AND CHANGE

Because of their small amounts of DNA or RNA and their rapid growth rates, microbes are capable of mutating and adapting quickly to environmental changes and selective pressures. The emergence of new viral infections, such as HIV and filoviruses, illustrates this point. Antigenic drift in influenza viruses is another subject of concern. It is likely only a matter of time before we have another major global influenza pandemic resulting from antigenic drift toward increased virulence.

The emergence of antimicrobial resistance further demonstrates the potential of microbial adaption. MDRTB, VRE, MRSA, and drug-resistant *S. pneumoniae* all reveal the potential seriousness of emerging antibiotic resistance. HIV resistance to zidovudine and the emergence of drug-resistant malaria should also raise concern.

BREAKDOWN OF PUBLIC HEALTH MEASURES

As resources become scarce and population growth escalates, particularly in developing countries, societies' existing infrastructures are unable to keep pace with demands placed upon them. Economic collapse, war, and other societal disruptions also contribute to the breakdown of social systems affecting public health. The recent rapid spread of cholera throughout the Americas because of inadequate sanitation is one example. Another is the emergence of MDRTB in New York City, which, in part, can be attributed to poor patient compliance with therapy, and which to some degree is related to inadequate follow-up and reduction in staff for the city's public health department.

A NATIONAL PREVENTION STRATEGY

The Institute of Medicine's report outlines numerous steps that need to be taken in the United States to deal with the health threats raised by emerging infections. In response, the Centers for Disease Control and Prevention (CDC) developed a national plan,⁹ the key components of which include 1) surveillance initiatives to improve detection of unusual pathogens and to identify and monitor trends in disease occurrence; 2) applied research in the fields of laboratory science and epidemi-

ology that can optimize public health practice; 3) prevention and control programs that enhance communication of public health information and assure prompt implementation of control strategies when specific problems are identified; and 4) a public health infrastructure at the local, state, and federal levels that can carry out the above programs.

As part of this plan, in October 1994, the CDC funded Emerging Infection Programs in Minnesota, Oregon, Connecticut, and northern California. All four programs are currently implementing surveillance for selected invasive bacterial diseases (such as antibiotic-resistant *S. pneumoniae*, meningococcal disease, invasive disease caused by groups A and B streptococcus, invasive disease caused by *Haemophilus influenzae*, and infections caused by VRE). In addition, the four sites are implementing surveillance for sudden unexplained deaths in persons under age 49 that may be caused by infectious agents. Once such cases are identified, appropriate laboratory specimens will be obtained to look for new or unusual pathogens (such as Hantavirus).

Finally, the four sites are working on epidemiologic projects involving a variety of other emerging infections, including *Ehrlichia* species; foodborne pathogens, such as *E. coli* serotypes, that produce shiga-like toxin other than serotype O157:H7; and cryptosporidiosis. Funding for these programs is expected to continue for at least five years.

To implement the Emerging Infections Program in Minnesota, the state Department of Health is working closely with hospital laboratories and infection control practitioners throughout the state. We also have a technical advisory group composed of more than 30 experts in a variety of areas, including clinical infectious diseases, microbiology, critical care, public health and epidemiology, and infection control.

PHYSICIANS' ROLE IN IDENTIFYING EMERGING INFECTIONS

Practicing physicians can assist public health efforts directed at handling emerging infections. First, physicians can, and should, identify cases of emerging infections and report such cases to public health authorities. This type of surveillance will help to identify cases of unusual disease and ascertain trends over time. Second, physicians should carefully evaluate their prescribing of antibiotics in both the office and the hospital. Inappropriate use of antibiotics is a major contributor to the emergence of community-acquired and hospital-acquired antibiotic resistance. Third, physicians can play a key role in educating patients about their risks of acquiring emerging infections and ways they can protect themselves. Such prevention messages are diverse and can cover a wide range of actions, from practicing safe sex, to thoroughly cooking hamburger and other meat products, to preventing tick exposures.

Our success in combating emerging infections

requires a close partnership between practitioners and public health officials. Together, we can provide reasonable strategies to address these issues and can keep them in proper perspective as we move into the next century.

MM

Kristine MacDonald is assistant state epidemiologist and assistant chief of the Acute Disease Epidemiology Section, and Michael Osterholm is state epidemiologist and chief of the Acute Disease Epidemiology Section at the Minnesota Department of Health in Minneapolis.

REFERENCES

1. National Center for Health Statistics. Annual summary of births, marriages, divorces, and deaths: United States, 1993. Hyattsville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, 1994;18-20. (Monthly vital statistics report; vol. 42, no. 13.)
2. Tomasz A. Multiple-antibiotic-resistant pathogenic bacteria: a report on the Rockefeller University Workshop. *New Engl J Med* 1994;330:1247-51.
3. Centers for Disease Control and Prevention. Drug-resistant *Streptococcus pneumoniae*—Kentucky and Tennessee, 1993. *MMWR* 1994;43:23-31.
4. Lederberg J, Shope RE, Oaks SC Jr., eds. *Emerging infections: microbial threats to health in the United States*. Institute of Medicine. Washington, D.C.: National Academy Press, 1992.
5. MacDonald KL, Osterholm MT. The emergence of *Escherichia coli* O157:H7 infection in the United States. *JAMA* 1993;269:2264-6.
6. Hedberg CW, MacDonald KL, Osterholm MT. Changing epidemiology of food-borne disease: a Minnesota perspective. *Clin Infect Dis* 1994;18:671-82.
7. Minnesota Department of Health. A national outbreak of salmonellosis associated with consumption of contaminated ice cream produced in Minnesota. *Disease Control Newsletter* 1994;22:69-71.
8. Barnett BJ, Koumans E, Bell R, et al. Locally acquired *Plasmodium vivax* malaria, Houston, Texas. Presented at the 44th Annual EIS Conference, Atlanta, March 27-31, 1995.
9. Centers for Disease Control and Prevention. Addressing emerging infectious disease threats: a prevention strategy for the United States. Atlanta: Centers for Disease Control and Prevention, 1994.

Physicians Clinic Internal Medicine Opportunity

Become a member of the Group Health, Inc., physician staff at our Physicians Clinic, St. Paul, Minnesota. We have a position available for a full-time board certified/board eligible Internal Medicine physician.

With a personable staff of four primary care physicians, this clinic offers a solid patient base and reasonable call and hospital responsibilities.

Group Health, Inc., a progressive managed care organization since 1957, is one of the largest multi-specialty group practices in the Midwest. Group Health offers its physicians a balanced lifestyle, excellent salaries, and a

generous benefit package that includes paid malpractice.

If you are interested in starting a practice at Physicians Clinic, please call Ann Mliner, (612) 883-5337, 1-800-472-4695, or send CV to: Group Health, Inc., A Division of HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.



HealthPartners

Spreading the Fear of Infectious Disease

"The Hot Zone," by Richard Preston and "The Coming Plague: Newly Emerging Diseases in a World Out of Balance," by Laurie Garrett tell the intriguing tale of our battle with infectious disease, but are these books overly alarmist?

Charles R. Meyer, M.D.

You must picture the consternation of our little town, hitherto so tranquil, and now, out of the blue, shaken to its core, like a quite healthy man who all of a sudden feels his temperature shoot up and the blood seething like wildfire in his veins.

—Albert Camus, "The Plague"

Bugs have always bothered us. From pesky viral colds to life-threatening pestilence, unseen critters have bedeviled humans. Medicine's first two millennia saw doctors battling infectious diseases with potions and poultice but without the foggiest concept of what caused them. Despite the 19th-century revelations of Pasteur, Semmelweis, and Koch, infectious disease claimed more lives than any other illnesses as the 20th century began. Definitive diagnosis and cure entered the infectious disease lexicon in the 1930s and '40s with the discovery of sulfa and penicillin. Surely the scourges of yesteryear would be conquered. Infectious disease would become an obsolete specialty. Medicine could concentrate on trickier stuff like cancer and heart disease.

It didn't happen. Resistant bacteria developed. Viruses could be diagnosed but rarely treated. New diseases appeared. Medicine's technological promise seemed hollow, and the old fear born in plague and TB years crept back. Michael Crichton captured this in his 1969 book, "The Andromeda Strain," portraying technology gone awry with the

release of a killer bacteria strain. The recent Ebola virus outbreak in Zaire has captured headlines. That the interest in the unseen threat of infectious disease is alive and well is apparent in the recent release and popularity of "The Coming Plague" and "The Hot Zone."

"The Coming Plague," (Farrar, Straus, Giroux, 1994) by *Newsday* science writer Laurie Garrett, is a collection of self-contained stories of "new" diseases and changes in the landscape of infectious diseases. Garrett covers Bolivian hemorrhagic fever, the Marburg and Ebola viruses, Lassa fever, the Swine flu scare, Legionnaire's disease, AIDS, toxic shock syndrome, and Hantavirus. Such a mix is hard to blend coherently, and the book does lack cohesiveness. Factual errors, though few, compromise some tales for the medically informed. However, each separate story is intriguing. The toxic shock syndrome story features Minnesotans Michael Osterholm, Ph.D., M.P.H., and the University of Minnesota's Patrick Schlievert, Ph.D.

Garrett attempts to weave certain themes throughout the book, although their consistency is loose. She decries political tampering with a rational battle against infectious diseases in places as disparate as Bangladesh (cholera) and the United States (AIDS). Travel restrictions on HIV carriers typify politics distorting science, hampering true public understanding of disease, and harming already sick people. Garrett's other

main theme is the impact of ecology, natural and human, on the march of old and new diseases. Malnutrition and poverty form the culture media for sexual behavior and the rampant spread of AIDS in Africa. The thinning ozone layer and global warming foster cholera outbreaks. Vanishing forests modify animal behavior and set up shop for *Ixodes dammini* and Lyme disease. Garrett is worried that we humans still do not understand ecological interdependence. She verges on alarmism in predicting microbial chaos reminiscent of past plagues.

Richard Preston also eclipses alarmism in "The Hot Zone," (Random House, 1994) setting the tone with the subtitle "A Terrifying True Story." "The Hot Zone" describes the initial "appearance" of the Ebola virus in Zaire in 1976 and its subsequent discovery in a shipment of research monkeys to a facility outside Washington, D.C., in 1989. The "Hot Zone" is the Level 4 Biohazard lab of the military, designed to handle the most contagious, lethal biological agents. Entry to the hot zone requires multiple barriers, space-suit garb, and strict protocols to prevent contamination of workers. Preston's book reads like a Crichton novel complete with date pacing, clipped character descriptions, dramatic dialogue, and hanger paragraphs at the end of chapters that leave the reader reaching to know what happens next. The action and the dialogue (apparently reconstructed from extensive interviews) is hyperbolic—people are

"stunned" and "shocked," and workers are constantly ripping gloves and getting contaminated with tainted blood. Good stuff for novels and movies, but a far cry from the dry clinical description of Ebola virus in the textbook "Harrison's Principles of Internal Medicine," which notes the "outbreak of an acute febrile hemorrhagic disease" in Zaire and Sudan with remarkable mortality (211 of 237 in Zaire in 1976). "The Hot Zone" is a good read and, like Crichton's novels, has spawned the recently released movie, "Outbreak."

Preston echoes Garrett in his fear of an imprudent humankind trampling a fragile globe: Perhaps the biosphere does not "like the idea of five billion humans. ... The earth's immune system, so to speak, has recognized the presence of the human species and is starting to kick in. The earth is attempting to rid itself of an infection by the human parasite. Perhaps AIDS is the first step in a natural process of clearance." As if deadly pathogens weren't scary enough, we now have Mother Earth rejecting us like a transplant.

Fear partly explains the popularity of these books. A recent *New York Times* editorial on fear in modern times quoted a psychologist who said "The Hot Zone" "scared the daylights" out of him. According to this article, fears of the unseen and unexpected are accelerating, with microbes merging with massacres and terrorists as reasons to quiver. Our promised savior, medicine, has abandoned us to the random threats of our world. Ebola and AIDS "tell us ... how little we know and understand of this world and one another, and that this ignorance is the true and unfailing wellspring of our fear."

These books, and the movie, are entertaining when put in perspective. But rational perspective is hard to come by when "The Hot Zone" ends with the ominous last predictive words, "It will be back." Preston's prescience seems spooky with the recent Zaire Ebola scare. But perspective means seeing 100 dying from Ebola in the recent outbreak when thousands in the same country perish from malaria. Perspective means acknowledging that sudden, devastating illness

unresponsive to medicine's marvels is no more frightening than tornadoes or random shootings and, in many ways, is more potentially preventable with epidemiological controls. We in medicine have a tall order to help the nonmedical public see that perspective and check the fear of the

unknown. We have to talk to Camus' healthy man and help him balance fear, entertainment, and science. **MM**

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

612-885-6224

1-800-842-6469



Look for this seal



The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBer), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this Seal. This Seal is your assurance that the product or service offered meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the  the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR... physicians working for physicians.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

FOTLAND

(continued from page 7)

I can provide."

A native of La Crosse, Wisconsin, Fotland was an Air Force medic for nearly four years. Managing sick call and suturing wounds at age 18 in the Aleutian Islands, he found himself drawn to nursing. He enjoyed the work and the people he met in the medical field. After earning his B.S. in nursing at Winona State University in 1983, Fotland worked for two years at the Veterans Administration Hospital in Minneapolis. He graduated from the College of St. Catherine's family nurse practitioner certificate program before moving to the Seattle area in 1985. He is certified as a nurse practitioner by the American Nurses Credentialing Center.

Fotland currently lives in Rochester with his wife and two young children, commuting to Kenyon for four 10-hour days a week. Fotland is the clinic's primary caregiver, but he's not isolated. Two support staff handle administrative tasks and some lab work at the clinic, and a physician from Mayo's Department of Family Medicine visits Kenyon two half-days a month. In addition, Fotland has almost instantaneous access to Mayo doctors in Rochester, Jacksonville, and Scottsdale.

"This is Mayo," Fotland says of the Kenyon clinic. "There's a core group of doctors in Rochester I can call anytime over direct phone lines. I can also call any doctor anywhere in the Mayo system. And some Mayo physicians have access to all the medical records here electronically." In fact, the Kenyon office will be "paperless" early this summer.

Fotland is also connected to Mayo physicians via telemedicine. Physicians in Rochester (and other Mayo sites) are literally present at examinations that Fotland conducts in a special exam room equipped with a camera, an electronic stethoscope and otoscope, and equipment to transmit ECGs and x-rays via a land-line telemedicine link. Fotland uses the system about three times a week. A Mayo physician recently used the

technology to diagnose a rare cholesteatoma in a 7-year-old Kenyon clinic patient, recounts Fotland. The next day, the physician examined the child personally. He admitted the video images were probably all he needed to make the diagnosis.

"This technology is the wave of the future," Fotland says. "The quality is so good, and you can use it for almost anything. Physicians anywhere can use me as the examiner."

The one-story Kenyon clinic has an unhurried feel that matches its small-town setting. Fotland is able to spend time teaching patients about prevention and to answer any questions thoroughly. Walk-ins are always welcome, and Fotland even makes house calls. He says Kenyon residents are happy to have a clinic in town because the closest doctor is about 15 miles away. "Patients accept me," he says. "They like the fact that I'm honest and will tell them when I don't know something."

Mayo, which has used NPs for 20 years, established its Kenyon clinic to see how well nurse practitioners would do as primary caregivers in a rural setting. The clinic building, which Mayo leases from the city of Kenyon, was built in 1976. A physician practiced there into the '90s, but the building had been vacant for about two years before Mayo arrived. "Many towns have trouble keeping physicians because they're isolated from colleagues, and their income is less," Fotland says. "It costs less to staff a rural clinic with a nurse practitioner, and physicians still control care through electronic links."

Joel Rueber, administrator of Mayo's Department of Family Medicine, which oversees the Kenyon clinic, is pleased with the project but unsure when it will be duplicated. "The Kenyon clinic has been very successful to date," he says. "Our patient numbers continue to increase steadily. But we're still focusing our energies on Kenyon and refining the process before establishing any other clinics."

The medical care is high quality, according to one of the physicians who visits, Joseph W. Furst, M.D., a family medicine specialist at Mayo. "Medically, [the Kenyon arrange-

ment] works pretty well," he says. "It takes awhile to get a feel for what a nurse practitioner is comfortable with, to determine what his limitations are. We also wondered how Jay would be received, because most people had always been seen by a doctor. But the community accepts Jay, and the physicians he deals with are happy with his work. This type of clinic seems to work well in places like Kenyon, where a medical practice isn't sustainable."

Despite growing acceptance of nurse practitioners by patients and physicians, Fotland believes the profession could gain wider respect by requiring NPs to have four-year registered nurse and master's degrees, and by adopting a national standard that would give all nurse practitioners the title some states allow—Advanced Registered Nurse Practitioners—instead of the prefixes used in Minnesota, such as "geriatric," "pediatric," "family," and "nurse-midwife."

Fotland, who thinks nurse practitioners will be independent of physicians in Minnesota someday, believes in the future of NPs. "We're accepted almost everywhere, and we do a good job," he says. "Studies show patients are satisfied with the care they receive from nurse practitioners. They're comfortable seeing us, and liability rates are lower because nurse practitioners are not doing as many invasive, high-risk procedures."

Whatever the future of nurse practitioners, Fotland plans to be part of it. With a second nurse practitioner starting at the Kenyon clinic in August, Fotland's immediate future calls for less time in Kenyon and one day a week in Rochester at Mayo's urgent care clinic. Someday, he'd like to work in a developing country (to catch a world-record fish, he jokes). In the meantime, he's satisfied with his work in Kenyon. "There's always a challenge in what I do, always something new to learn," he explains. "I enjoy my autonomy and the responsibility of caring for patients." **MM**

James Bohen is a free-lance writer living in St. Paul.

NONPHYSICIAN PRACTITIONERS

(continued from page 16)

welfare of the public. "And I see the value in a checks-and-balance system."

Having a physician available for support and consultation is vital to a physician assistant's practice, says Helgeson. In hospital settings, physicians have peer review. In rural areas, they have relationships with other doctors with whom they can confer. "Just as it doesn't hurt to have physicians looking over physicians' shoulders, physician supervision of physician assistants helps to ensure the quality of care that a physician assistant is providing."

INCREASING ACCESS AND PROMOTING COLLABORATION

Many people see physician assistants and nurse practitioners as playing a key role in helping to bridge the primary care gap, especially in rural and other underserved areas. "We've found that attracting physicians to rural areas is more of a challenge, although there is a shortage in all areas [of the state]," says Angela Ansett, program assistant for placement and retention at the Minnesota Center for Rural Health.

Rural Minnesota is a "crying area of need," agrees Dawn Ludwig, PA-C, director of the physician assistant program at Augsburg College. In soliciting applications for the program, the selection committee made an extra effort to recruit people from rural and other underserved areas who would be interested in eventually practicing in those same areas, says Ludwig. "We are hoping that most of our students' preceptorships will be in rural or underserved areas in the Twin Cities."

All five of the nurse practitioner programs in Minnesota participate in the Collaborative Rural Nurse Practitioner Project, designed to improve educational access for rural NP students, develop rural practice education sites, and develop opportunities for NPs to establish practices in rural communities.

With similar goals in mind, the Adult Nurse Practitioner program at Winona State University offers long-distance training opportunities to nurses already living in rural areas who are invested in their community and plan to stay there upon completing the program. During the first year of coursework, long-distance students attend the university only one day a week and eventually do all of their clinical training in their home communities. This year, 10 of the 14 clinical students in the program were living and studying in rural settings.

In 1994, Minnesota legislated a Nurse Practitioner Promotion Team Program to further promote the development of collaborative practices between physicians and nurse practitioners throughout the state. Administered through the Office of Rural Health (ORH), the program includes 10 established teams of nurse practitioners and physicians who will begin meeting this summer with other providers who have expressed an interest in developing similar relationships.

"It's not that we're trying to establish anything new, but to promote and expand something that is already working well in many practices," explains Lorry Colaizy, recruitment and retention coordinator at ORH. "Rather than having the state go out there and tell people how they should do it, we're having teams who are already committed to the idea of collaborative relationships meet provider to provider, face to face, with people who are interested."

"When we met with the teams to discuss the program, we were somewhat surprised to find that [they had] no turf issues; there was no use of 'physician extender' language," adds Colaizy. "These are people who are very committed to collaboration."

The ORH has also developed a reference manual for those interested in the logistics of setting up a collaborative practice. The hope is that the promotion program will one day include physician/physician assistant teams as well, Colaizy adds.

To help promote the idea of collaborative relationships among medical and nurse practitioner students, ORH is also initiating a Collabora-

tive Nurse Practitioner Program this fall. The first year will include sites at the University of Minnesota-Duluth and the College of St. Scholastica. Participating teams of students will work with their professional counterparts to gain an understanding of how collaborative and interdisciplinary practices work, Colaizy explains. "We may not be able to change the thinking of some older physicians about the way they work, but perhaps we can influence some of the students who will be entering the profession."

If the current trend goes as predicted, nonphysician practitioners will do a significant amount of family practice in the future, says Caledonia family physician Alan Fleischmann. "It's cost-effective, and the important thing is to provide good quality, caring health care. We [in the medical profession] need to do all we can to cover all the bases, including in rural and underserved areas. If doctors don't go [to those areas], we need to get nurse practitioners and physician assistants out there to provide care."

MM

ACKNOWLEDGMENT

Special thanks to the nurse practitioners, physician assistant, and patients at Park Nicollet Clinic Health System Minnesota who agreed to be photographed for this article.

Katie Colón is a free-lance writer in Champlin, Minnesota, specializing in health care and disability-related subjects.

ODDS

(continued from page 9)

are you experiencing more of that chest discomfort?" I asked, needing something to concentrate on, something to do. He asked me to hold his hand. "Oh, God, I can't escape," I thought, not knowing how to answer his questions. Mr. Richards didn't say much else. He just stared at the ambulance ceiling, perhaps too afraid to ask any more questions. I guess he knew he was in trouble, and there was no escaping for him, either.

Mr. Richards' hospital course was turbulent. He developed congestive heart failure and pulmonary edema. He was treated with nitroglycerin, dopamine, dobutamine drips, and judicious amounts of analgesics. He and his family were advised of grim statistics and his poor chances of survival.

Every day, I would see Mr. Richards—Sam—in the ICU; he would ask to hold my hand and question me again, "Am I going to

die?" He wanted to know his chances of survival. I spent much time trying to reassure him, remembering Mr. Goldman's need for hope. I felt like a cheerleader at times, holding his hand and reviewing his life's accomplishments. We talked about his wife, six children, and his many hobbies and interests. He realized he had much to live for, which seemed to give him the will and courage to survive. Within days, he began to improve steadily and gained strength. Two weeks later, he was home, recovering uneventfully.

During Sam's hospital stay, we talked about our mutual love and hate of golf. We made plans to play a round before the snow flew. Early in the fall we got our chance. Not only was he able to walk nine holes, but he convincingly displayed his golf superiority. He teased me about my ability to play both sides of the fairway and the distance I could hit the ball in the wrong direction. A week or two after the golf round, he left a grocery bag full of golf balls for me at the clinic. His note said I would need a

large number of balls if I continued to play the way I had.

My encounters with Sam dwindled over the following months. He eventually left the area to pursue other interests, including golf. The bag of balls he gave me lasted longer than he thought. I am still using them to play both sides of the fairway, and I manage to find most of them. The golf balls remind me that odds and statistics can be harsh; patients also need hope and encouragement to survive. Fear can distort a caregiver's message; patients hear what they expect and what they want to from providers and often concentrate on the negative. Caring for a patient involves more than providing medication to relieve discomfort. Hopefulness is potent medicine that aids patients' strength, builds their courage, and improves their chances of beating the odds. MM

Stephen Rapatz-Harr is a family practice physician assistant at St. Cloud Medical Group in St. Cloud, Minnesota.

CONTINUING MEDICAL EDUCATION

ST. PAUL-RAMSEY MEDICAL CENTER

Mark your calendar now for these upcoming conferences:

FALL-SPRING CONFERENCE SCHEDULE

1995

- October 5-6: Infection Control in Long Term Care Facilities-Part I, St. Paul (Part II is December 11-12)
- October 21: Justification of Aquatic Therapy: Functional Outcomes, Clinical Research and Public Awareness, St. Paul
- November 9-10: Changing Surgical Practices-1995, St. Paul
- November 16-18: Strategies in Primary Care Medicine, St. Paul
- December 7-9: Cardiopulmonary Medicine, St. Paul

1996

- February 23: Burn Care Today, St. Paul
 - March 7-8: Family Medicine Today, St. Paul
 - March 28-29: Critical Care 1996, St. Paul
 - April 12: ENT Update for Primary Care Physicians, St. Paul
 - April 18-19: Ob/Gyn Update 1996, St. Paul
- INFORMATION AND REGISTRATION: *Continuing Medical Education, St. Paul-Ramsey Medical Center*
 640 Jackson Street, St. Paul, MN 55101
 Phone 612/221-3992, Fax 612/292-4773

CME

640 Jackson Street
 St. Paul, MN 55101
 (612) 221-3992

RAMSEY

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.*
Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards
 you with WorldPerks miles. Earn 1 mile for every
 dollar in retail purchases with your WorldPerks Visa
 card. Earn WorldPerks miles for every dinner you
 eat. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than
 11 million locations with your WorldPerks Visa, and
 you'll fly free faster on Northwest Airlines. We have
 made applying easy. Simply call 612-623-2860 or
 toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
 BUSINESS RESOURCES

*A physician-owned, for profit
 corporation of the MMA and HMS*

To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)

*Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

People and Places Making Medical News

People

Community Leaders Receive Achievement Awards

Eugene Ott, M.D., and Beverly Propes recently received the first annual Mary M. Gates Volunteer/Staff Achievement Award for their partnership efforts to ensure healthy development of children and families in the greater Minneapolis area. The awards were presented in May at the United Way of America's National Leadership Conference held in Cleveland, Ohio, by Bill Gates Sr., son of the late Mary Gates, a lifelong United Way Volunteer for whom the award was named, and by Louis Sullivan, M.D., former secretary of Health and Human Services.

Ott is former chair of the Hennepin Medical Society Board and volunteer chair of the HMS/Success By 6@ Phillips & Powderhorn Health Partnership Committee. He and Propes, community initiatives director for United Way of Minneapolis Area, created a partnership to help improve access to prenatal and child health care services for women in low-income neighborhoods of Minneapolis. The partnership brought together physicians to learn why women in certain low-income neighborhoods were not seeking prenatal care and to develop strategies to make health care more accessible.

Park Nicollet Clinic Presents Community Service Awards

Park Nicollet Clinic recently presented 1995 Community Service Awards to Thomas W. Hoban, James Craig, M.D., and Carl Pohlrad.

Hoban, former executive vice president and chief executive officer of Hennepin County Medical Society (now Hennepin Medical Society), was directly

involved with the creation of Physicians Health Plan, which later evolved to Medica, and with the initiation of a central credentialing system in the Twin Cities. He has served on the boards of directors of the College of St. Benedict, the Minneapolis Visiting Nurse Service, and the United Way of Minneapolis.

Craig, vice president, director of Health and Human Services for General Mills, was awarded for his service to General Mills employees and their families and for providing voluntary services to a number of community and professional organizations, including Altcare, the Minneapolis Academy of Medicine, the American Medical Association, and the American College of Occupational and Environmental Medicine.

Pohlrad, president of Minneapolis-based Marquette Bank and owner of the Minnesota Twins baseball team, has been involved with a number of boards, including the Foundation of HealthSystem Minnesota, Methodist Hospital, the 1991 Special Olympics Games, and the Minnesota Medical Foundation. He is a founding director of the Boys' and Girls' Clubs of Minneapolis and a past president of the Greater Minneapolis Chamber of Commerce.

Fairview VP Named National Health Care Leader

Scott Wordelman, president and chief executive officer of Chisago Health Services and a Fairview Health System senior vice president, was named one of the nation's four Emerging Leaders in Health Care for 1995 at the 11th annual leadership search led by Korn/Ferry International. The award identifies outstanding leaders under the age of 40 and honors their leadership abilities.

Wordelman, of Chisago City,

has spent the past two years guiding the Chisago Health Services board, physicians, community, and staff through strategic planning that resulted in CHS becoming a fully owned subsidiary of the Minneapolis-based Fairview Health System on July 1, 1994.

Muesing Appointed Colonel

Mark A. Muesing, M.D., of St. Cloud was promoted to colonel of the Minnesota Army National Guard at a ceremony in March. Muesing, a practicing family physician at the Veterans Affairs Medical Center in St. Cloud, joined the Minnesota Army National Guard in October 1985. In 1994, Muesing became the State Surgeon, responsible for the overall management of Health Services and medical personnel in the Minnesota Army Guard.

MAFP Elects New Officers

The Minnesota Academy of Family Physicians elected the following 1995-96 officers at its annual meeting in May: Paul Van Gorp, M.D., Long Prairie, president; Patricia Lindholm, M.D., Fergus Falls, vice president; Kenneth Kephart, M.D., Minneapolis, president-elect; Timothy Komoto, M.D., Minneapolis, board chair; David Thorson, M.D., White Bear Lake, speaker of the house; Bradley S. Johnson, M.D., St. Cloud, vice speaker; Pamela Dumke, M.D., Minneapolis, treasurer; and Nancy Baker, M.D., St. Paul, immediate past president.

The following officers were presented awards: Timothy Pryor, M.D., Minneapolis, Merit Award; Byron Crouse, M.D., Duluth, Teacher of the Year Award; David Heine, Rochester, Medical Student Award for Contributions to Family Medicine; Barbara Elliott, Ph.D., Duluth, President's Award. Deborah Sieling Dittberner, M.D., Minneapolis, and Karen Karlinski,

M.D., St. Paul, both received the Resident of the Year Award.

MUS Appoints New Officers

Carl S. Smith, M.D., Minneapolis, recently assumed the presidency of the Minnesota Urological society. MUS elected the following new officers: John K. Matsuura, M.D., St. Cloud, president-elect; David E. Patterson, M.D., Rochester, past president; Michael H. Wipf, M.D., Minneapolis, secretary-treasurer; and Cesar J. Ercole, M.D., St. Paul, member-at-large.

MOS Elects New Officers

Mark J. Carlson, M.D., Duluth, recently assumed the presidency of the Minnesota Orthopaedic Society. Other newly elected officers are James R. Larson, M.D., Edina, president-elect; Douglas A. Drake, M.D., Edina, secretary; Michael G. Orr, M.D., St. Cloud, member-at-large; Paul C. Matson, M.D., Mankato, MMA Interspecialty Council Representative. Edward C. McElfresh, M.D., Minneapolis, is the society's representative to the American Academy of Orthopaedic Surgeons Board of Councilors.

MSP Appoints Officers

John T. Crosson, M.D., Minneapolis, recently assumed the presidency of the Minnesota Society of Pathologists. David J. Blomberg, M.D., Duluth, was elected director, and James S. Hernandez, M.D., St. Cloud, was elected vice president.

Fairview Elects Board Members

Fairview Ridges Hospital, Fairview Riverside Medical Center, and Fairview Southdale Hospital recently elected new board members.

Jean Bieraugel, M.D., Gregory Coleman, the Rev. Michael Foss, Beverly A.T. Mackey, Donald Moffatt, and Betty Nowicki were elected to the Fairview Ridges Board of Trustees.

New members of the Fairview Riverside Board of Trustees are William A. Callahan, M.D.,

the Rev. Marlene Whiterabbit Helgemo, Lois Sinn Lindquist, Valerie Halverson Pace, and Lyall Schwarzkopf.

Thomas Rogers and *Minnesota Medicine* Editor-in-Chief Charles R. Meyer, M.D., were elected to the Fairview Southdale Board of Trustees.

ASCRS Appoints President-Elect

David A. Rothenberger, M.D., of St. Paul was appointed in May president-elect of the American Society of Colon and Rectal Surgeons at the society's annual meeting in Montreal, Quebec, Canada.

Rothenberger is a clinical professor and chief, Division of Colon and Rectal Surgery at the University of Minnesota Hospital and Clinic in Minneapolis, and is president and chief executive officer of Colon and Rectal Surgery Associates, Ltd., a 12-physician private practice group based in Minneapolis and St. Paul. He is a physician member of the Board of Directors of Medica Health Plans.

P l a c e s

Allina Funds Violence Prevention

Allina Foundation in June launched the Violence Prevention Research Initiative, a \$250,000 fund dedicated to community-based research into violence prevention.

The initiative will provide funds to principal investigators to research and document the health care costs associated with violence and to evaluate the effectiveness of violence prevention strategies.

The research fund was announced in conjunction with a Minnesota Medical Association campaign to make parents aware of the harm violent TV programs, movies, and video games cause to children.

Mesabi Acquires New Name, Selects Board Members

The former Mesabi Regional Medical Center in Hibbing has changed its name to University

Medical Center-Mesabi, reflecting the center's merger with the University of Minnesota Health System in April.

The center also appointed six community representatives to its board of directors: Richard Kasner, Richard Bugliosi, John Fort, Patrick Gates, David Naughtin, and Norma Schleppegrell.

John Shenk, M.D., will represent Mesaba Clinic on the board; Mark Wagner, M.D., will represent Duluth Clinic-Adams; and Daniel Vechell, M.D., will represent independent physicians. Four UMHS representative were also appointed: Michael Fay, member, Board of Governors; Gregory Hart, UMHS president; Peter Rapp, University Hospital and Clinic general director; and Robert Wilson, M.D.

St. Paul-Ramsey Opens New Emergency Center

St. Paul-Ramsey Medical Center plans to open a new state-of-the-art emergency center this month that will transform the way emergency care is provided by the hospital. The new center, a \$7.5 million reconstruction and renovation, will offer patients and their families a more friendly, private, spacious environment. Other features include a computerized, on-line patient log system and a separate telephone tracking system that allows almost instantaneous communication among physicians, nurses, and staff; a children's play area; and private waiting rooms for families with critically ill or injured members.

St. Paul-Ramsey Opens New Women's Health Center

St. Paul-Ramsey's Health Center for Women opened in May a new, expanded facility located at 2635 West University Avenue at the intersection of Highway 280 in St. Paul. The new center spans 7,500 square feet and includes 10 exam rooms and two procedure rooms.

The Health Center for Women became the metro area's first all-female staff clinic at St. Paul-

Ramsey Medical Center in 1986. Since then, the concept and the center have grown; increasing demand for services provided by the center led to the expansion.

HealthEast, Children's Health Care Plan Community Health Study

HealthEast and Children's Health Care plan to collaborate on a study of community health needs in the southeast suburbs of the Twin Cities. The \$180,000 study will focus on West St. Paul, South St. Paul, Eagan, Inver Grove Heights, and Mendota Heights and the specialized needs of Woodbury, Cottage Grove, and other south Washington County communities.

Residents, community leaders, and officials of HealthEast and Children's Health Care will participate in community focus groups, surveys, and organized work groups. Results will help health care providers determine what services the communities need. HealthEast and Children's hope to improve child and family health and to increase children's access to specialized pediatric services.

Comfrey Hospital to be Treatment Center for Adolescent Girls

A once-closed hospital in the southwestern Minnesota town of Comfrey will reopen its doors in early August to serve as a treatment center for troubled adolescent girls. The former Comfrey Hospital will receive \$3,500 per month from the Leo A. Hoffmann Center of St. Peter, Minnesota. Hoffmann Center will be paid about \$125 to \$130 per day from county court systems or social service agencies to house the girls, who will attend classes and undergo treatment for emotional or behavioral problems.

Teachers from Comfrey schools will conduct classes at the new center. As the girls advance through the treatment program, some may take classes at the local high school.

Comfrey's hospital was closed in 1993 after the town's only doctor died.

Socioeconomics

Most Hospitals Predict Independence, More Collaboration

Despite fears of widespread consolidation in the health care industry, most Minnesota hospital administrators predict that their facilities will participate in integrated service networks (ISNs) but not be owned by them. According to a recent survey by the Minnesota Hospital Association (MHA) and the Metropolitan Healthcare Council (MHC), 66 percent of hospital administrators believe that by the year 2000 their hospitals will contract with ISNs or CISNs (community integrated service networks) to provide services to enrollees. Twenty-five percent believe their facilities will be part owners in at least one ISN or CISN.

Only 20 percent of the Minnesota hospitals responding to the survey are owned by hospital systems. Only 10 percent of administrators believe their facilities will be owned by ISNs or CISNs in the year 2000.

More than half of the administrators responding to the survey (52 percent) predicted that by the year 2000 their hospitals will be part of a health care cooperative. "The co-op is becoming a popular form of collaboration because its members can remain independent while acting and working collectively," said Stephen Rogness, MHA president.

Allina Buys Three St. Paul Clinics

Allina Health System has purchased Internal Medicine Associates, Parkview Internal Medicine, and United Internal Medicine, all St. Paul-based clinics. Allina, the state's largest clinic owner, now has nearly 60 clinics.

The three recently purchased clinics have long histories with Allina's United Hospital. Together, they include 16 internists, but four of the seven physicians at United Internal Medicine have decided to join Aspen Medical Group.

Northfield Clinic Joins HealthSystem Minnesota

Family Physicians of Northfield joined HealthSystem Minnesota, an integrated health care system based in St. Louis Park, on June 1.

"For many years, Family Physicians of Northfield has worked with Park Nicollet Clinic HealthSystem Minnesota and Methodist Hospital HealthSystem Minnesota to treat patients needing hospitalization or specialty care," said Kenneth Sansome, M.D., one of the clinic's four family practice physicians. "This partnership will allow our clinic continuing independence and local management, while providing access to a broader range of medical and administrative services."

Nurses Negotiate Contract With 12 Twin Cities Hospitals

The Metropolitan Healthcare Council, representing 12 Twin Cities hospitals, and the Minnesota Nurses Association, representing the hospitals' 7,000 registered nurses, have negotiated a three-year contract. The agreement provides the nurses more control over their duties, greater job security, benefits such as increased tuition and retraining reimbursement, added pay for special certification or a master's degree, workplace violence protection and safety improvements, as well as a 3 percent pay increase in each of the first two years and a 2.6 percent increase in the third year.

The contract says hospitals "will make reasonable and continuing efforts" to minimize the use of nurses for housekeeping, dietary, clerical, and similar tasks.

Registered nurses nationwide have expressed concern about hospitals replacing them with lower-paid technical or assistant nurses.

A goal of the nurses was to clarify the duties in relationship to less-trained nursing personnel. The contract reads, "Only a registered nurse will assess, plan, and evaluate a patient's or client's nursing care needs."

The hospitals will form committees to monitor who does what and to analyze data regarding patient care under different arrangements.

Law & Policy

State's Case Against Tobacco Industry Survives First Challenge

Ramsey County District Judge Kenneth Fitzpatrick denied a request from the tobacco industry to toss out the antitrust case that the Minnesota Attorney General's Office and Blue Cross and Blue Shield of Minnesota have filed against the industry.

The suit alleges that the tobacco industry has deceived the public about the dangers of smoking and has conspired to manipulate the market (for more details about the suit, see "Industry Under Fire: Minnesota v. the Tobacco Industry" in the April *Minnesota Medicine*, page 23).

In a prepared statement, Attorney General Hubert Humphrey III said, "This order is a setback for the tobacco industry. The denial of their motion to dismiss means the industry has fallen flat on its attempt to land an early knockout punch."

Rates, Trends, Data

Infant Mortality Down in St. Paul

The infant mortality rate for St. Paul has dropped to an average 7.3 deaths per 1,000 live births for the three-year period ending in 1993, bringing its rate down to the statewide average for the first time in 20 years, according to Neal Holtan, M.D., St. Paul's acting public health director. The Minnesota rate has ranged from 7.1 to 7.5 during that same period. St. Paul's rate for 1993 was 4.9, but Holtan said one-year comparisons are not realistic.

The new rate is lower than that of Minneapolis, which averaged 12 deaths per 1,000 live births between 1991 and 1993.

Holtan said St. Paul has been

working hard to lower its infant mortality rate. "We've tried to strengthen ties with all the people working in communities," he said in a *St. Paul Pioneer Press* article. He said a key to decreasing infant deaths is letting people know

where they can go for support, such as child care, and for information on safety and other issues. He also attributed the lower rate to more immunization and better care for pregnant women.

continued

HealthEast Capitol Medical Laboratory offers solutions

Providing services to physician office laboratories, long term care facilities, home care agencies, group homes, and corporate health and wellness programs • Professionally staffed • Locally owned and operated • Open 24 hours, 7 days/week • Member HealthEast Community Based Services

Providing solutions and expanded services for your office. For more information, contact CMLMarketing at (612)

232-3246

HealthEast Capitol

Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102

Customer Service: (612) 232-3500

• Minnesotans serving Minnesotans •

Gonorrhea Cases Up in Minnesota

Gonorrhea cases in Minnesota increased 32 percent last year, from 2,543 cases in 1993 to 3,346 in 1994, according to the Minnesota Department of Health. The rate per 100,000 population jumped from 56 to 74 cases. In the past decade, the rate has decreased an average 8.5 percent annually.

Public health officials said they don't know why the rate increased. Some states have reported cases of gonorrhea resistant to the antibiotic fluoroquinolone, but samples tested at the Minnesota Department of Health show that the Minnesota cases were susceptible to the currently recommended antibiotics, ceftriaxone and ciprofloxacin.

The rates, which increased among all age groups and in all parts of the state, remained highest for adolescents, non-Hispanic blacks, and residents of urban areas. According to the Centers for Disease Control and Prevention, rates for many states increased last year.

More Women than Men Entering Top Medical Schools

Three top medical schools, Yale, Harvard, and Johns Hopkins, are among 18 of the country's 126 medical schools with more women than men in the first-year class for the 1994-95 academic year. Yale's class is 56 percent women; Harvard's and Johns Hopkins' classes are 53 percent women. It's the first year the schools have had a majority of women students. Medical school officials do not know the reason for the shift.

Nationwide, about 42 percent of students applying to U.S. medical schools in the past three years have been women.

Medical Research

Air Pollution Causes More Than 400 Twin Cities Deaths Annually

Air pollution is tied to more than 400 deaths per year in the Twin Cities, which is 3 percent of the

area's annual 14,250 deaths, according to a study by the National Institutes of Health. The study, which was presented at the International Conference of the American Thoracic Society/American Lung Association in late May, looked at death rates due to air pollution in nine metropolitan areas: New York City, Atlanta, Houston, St. Louis, Chicago, Detroit, the Twin Cities, San Francisco, and Los Angeles. Most deaths were of elderly people with breathing problems such as asthma and chronic obstructive pulmonary disease.

The death rate due to pollution in the Twin Cities is lower than in cities like Los Angeles and San Francisco, where 4 percent to 5 percent of deaths are attributable to air pollution, but higher than in Houston, where only 1 percent of deaths are related to pollution. According to the study, many Twin Citians are protected from the effects of pollution because they have air conditioners—about 60 percent of households in the 1980 census. Houston's death rate is so low because about 90 percent of homes have air conditioners.

Frequent Follow-Up Cuts CHF

Monthly physician follow-up for patients with congestive heart failure reduces the death rate by about one-half and cuts treatment costs by 20 percent, according to a study by the Minneapolis Heart Institute. Irv Goldenberg, M.D., principal investigator for the study, reported the findings at the third annual International Congress on Heart Failure in Geneva, Switzerland, in late May.

The study included 76 patients with congestive heart failure. The 50 patients seen monthly by a specialist had average 10-month treatment costs of \$5,981. The 26 similar patients seen quarterly by primary care physicians had average 10-month treatment costs of \$7,438. The clinic costs were significantly higher for the patients seen by specialists (an average \$1,409 per patient compared with \$221), but these costs were out-

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice OB/GYN Urgent Care Internal Medicine

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



weighed by lower emergency department/hospital costs.

Of the 50 patients seen by specialists, 16 (32 percent) were hospitalized or visited the emergency department, compared with 15 (58 percent) of the 26 patients seen by primary care doctors. Ten percent of the specialized care patients died during the 10-month study, compared with 19 percent of the primary-care patients.

Goldenberg said the key to lower costs and mortality rates was frequent physician visits, allowing the doctors to adjust medications as needed.

MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JULY 1995

July 22 **Anatomy and Arthroscopy** American Association of Clinical Anatomists and the Mayo Foundation; Mayo Medical Center, Rochester, MN. CONTACT: Barbara Porter, Mayo Foundation, Continuing Medical Education, Siebens 5, 200 First Street SW, Rochester, MN 55905; 507/284-0026.

AUGUST 1995

Aug. 18-19 **Advanced Life Support in Obstetrics** Hennepin County Medical Center/Hennepin Faculty Associates; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

Aug. 27-30 **Minneapolis Transplant Congress: New Immunosuppressive Drugs** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

SEPTEMBER 1995

Sept. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Mental Health Issues for Primary Care Physicians** Allina Health System; Hotel Sofitel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12 **Molecular Biology for Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 14-17 **Mechanical Ventilation: Principles and Applications** University of Minnesota Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington

Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 16 **Endorectal Ultrasonography** University of Minnesota Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 22-23 **Nursing Home Medical Directors** University of Minnesota Continuing Medical Education; Sheraton Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 28-30 **Animal Models of Cardiac Dysfunction** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

SEPTEMBER 1995

Sept. 22-23 **The Child With Unusual Infections** University of Minnesota Continuing Medical Education; Park Inn, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

OCTOBER 1995

Oct. 7 **Surgical Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

ENDURING MATERIALS

Videotape **Bloodborne Pathogens** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

MMA-Accredited CME Sponsors

• The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor CME activities for local physicians. • Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating the amount and category of credit for CME activities. • CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." •

The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- Itasca Medical Center, Grand Rapids
- Virginia Regional Medical Center, Virginia

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

Sept. 29-30 **Recent Developments in Epilepsy and Neurology** Allina Health System and Minnesota Epilepsy Group; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

OCTOBER 1995

Oct. 5-7 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 6-7 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 6-7 **Front Line Neurology** Allina Health System; Marquette Hotel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 7 **Orthopedic Symposium** Allina Health System; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

If you are a board-certified physician or a candidate for board certification in one of the following specialties, you may qualify for a bonus of up to \$30,000 in the Army Reserve.

- Anesthesiology
- General Surgery
- Thoracic Surgery
- Pediatric Surgery
- Orthopedic Surgery
- Colon-Rectal Surgery
- Vascular Surgery
- Neurosurgery

A test program is being conducted which offers a bonus to eligible physicians who reside in certain geographic areas (Pennsylvania, West Virginia, Ohio, Michigan, Illinois, Indiana, Wisconsin, Minnesota and Iowa). You would receive a \$10,000 bonus for each year you serve as an Army Reserve physician—for a maximum of three years.

You may serve near your home, at times convenient for you, or at Army medical facilities in the United States and abroad. There are also opportunities to attend conferences and participate in special training programs, such as the Advanced Trauma Life Support Course.

To learn more about the Army Reserve and the Bonus Test Program, call one of our experienced Medical Personnel Counselors:

CALL COLLECT:
CPT. RICK OTTO
612-854-7702

ARMY RESERVE. BE ALL YOU CAN BE.®

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., July 15 for September ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439.

(*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

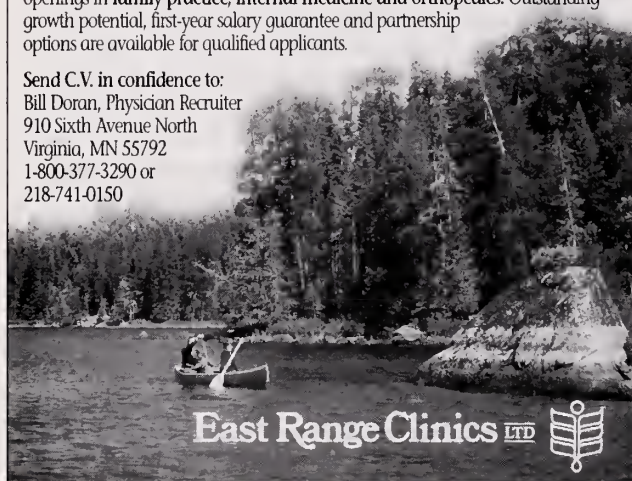
Just minutes from your back door and you're into some of the only real, NATURAL wilderness areas remaining in America.

Isn't it time to get away?

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park—two natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd., a 30-physician, multi-specialty clinic, currently has openings in family practice, internal medicine and orthopedics. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:
Bill Doran, Physician Recruiter
910 Sixth Avenue North
Virginia, MN 55792
1-800-377-3290 or
218-741-0150

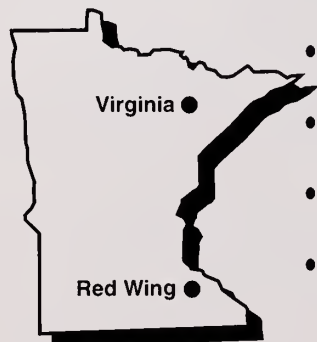


East Range Clinics LTD



**COASTAL
PHYSICIAN SERVICES
OF THE MIDWEST, INC.**

Your Private Practice Alternative in the State of Minnesota



- No on-call
- Medical Directorships
- Assured Income
- Group Practice

Brian Nunning
800-326-2782 • FAX: 314-291-5152

3221 McKelvey, Suite 106, St. Louis, MO 63044

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Issues in Primary Care Conference: Friday, September 15 to Saturday, September 16, 1995, Landmark Resort and Conference Center, Egg Harbor, Wisconsin (Door County). Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449; 800/541-2895. *2-7/95

Internal Medicine—Minneapolis: BC/BE general internists needed to join the Department of General Internal Medicine of a 385-physician multispecialty clinic in desirable Twin Cities area. Currently, we have two positions avail-



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123

able at our Burnsville office. These are traditional practices with both ambulatory and hospital components. Salary and benefits are highly competitive. For additional information contact Patrick Moylan at 612/932-5986, or send CV and letters of inquiry to Professional Practice Resources, Park Nicollet Clinic HealthSystem Minnesota, 3800 Park Nicollet Blvd., Minneapolis, MN 55416; or fax: 612/932-6490. 2-7/95

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441. (*7/95-R)

Attention Physicians and Surgeons: We have locum tenens and permanent positions available nationwide. Please contact: Physician Search Consultants, 101 27th Avenue SE, Minneapolis, MN 55414; 612/627-9350. 2-8/95

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. 3-9/95

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

•••EMERGENCY MEDICINE POSITIONS•••

Northern and Central Minnesota

Emergency Medicine opportunities are available now. Full-time and part-time staff positions in moderate volume emergency departments. Attractive, comprehensive benefit packages with paid malpractice. Beautiful surroundings, numerous recreational activities, excellent schools in economically stable, safe, family-oriented communities. Practice medicine in friendly professional environments at a pace that allows ample time for family and leisure activities. Call today for more information.

Iowa

Opportunities for prosperous lifestyles in several friendly Iowa communities. Secure practices with progressive physician-owned group. Excellent compensation packages, pleasant working conditions with appreciative patients. Various locations, reasonable housing in safe communities with top-notch school systems and Midwest values. Life in Iowa is measured by its warm, friendly people and quality lifestyles. Come join us.

- Call 1-800-458-5003 or send CV to Sheila Jorgensen, P.O. Box 1260, Waterloo, IA 50704

•••••

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group
Health Plan today and put time
on your side.



Central Minnesota
Group Health Plan

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/FOE

NURSES!

**ENHANCE YOUR CAREER ★ BECOME A NAVAL RESERVE NURSE
\$18,000-\$30,000 BONUSES**

Motivated nurses around the United States are enhancing their leadership skills by joining the Naval Reserve Health Care Team. Through this flexible, part-time opportunity you can experience the pride and prestige of being a Naval officer. Serve your country with other medical professionals while you receive training in military medicine. If qualified, you may be eligible



You and the Naval Reserve.
Full Speed Ahead.

for a \$6,000 to \$10,000 yearly bonus for three years in addition to a competitive pay and retirement package. Other benefits include financial assistance for advanced nursing education, worldwide travel opportunities, shopping at military stores, and full-time term life insurance.

If you would like to know more about wearing the gold of a Naval Reserve nurse, call:

1-800-633-3209

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE, to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-8/95

Family Physician to join the medical staff of five family practitioners in a well-established, growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Work in two newly constructed, modern clinics; one is attached to the hospital. Excellent subspecialty support, progressive community hospital, diverse patient population. Guaranteed salary with incentive plan and a broad range of benefits. Call collect, 612/532-3154, or write to Frederick W. Haack, Administrator/CEO, Mille Lacs Health System, PO Box A, Onamia, MN 56359. *6-9/95

Urologist to join practice in pleasant Midwestern city. Modern hospital nearby. Very little managed care. Prefer oncology background. Please send résumé to Watertown Urology, 600 Fourth Street NE, Watertown, SD 57201; Fax: 605/886-9204. 2-8/95

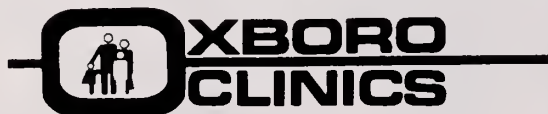
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office
Fairview Clinic Services

600 West 98th Street, Suite 390
Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine	OB/GYN
Internal Medicine	Neurology
Orthopedic Surgery	Pediatrics
Noninvasive Cardiology	Urology

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-4592.

Family Practitioner • Internist

BOTH Want the best of
worlds?

Live and work in a rural community—yet have easy access to the educational, cultural, shopping, and entertainment opportunities of the big city. Enjoy all the benefits that go with small-town living—good neighbors, safe schools, affordable housing, abundant recreational choices—and go to the city when you want!

St. Croix Falls, Wisconsin is located just over the scenic St. Croix River from Taylors Falls, Minnesota and within 45 minutes of the metropolitan Twin Cities. With 25,000 households within the clinic service area, River Valley Medical Center is the region's largest and most diversified practice group—13 family practitioners, 2 internists, 2 general surgeons, 2 orthopedic surgeons and a physician assistant. Clinic is attached to a 50-bed acute care hospital with a wide range of services.

Guaranteed first-year salary with second-year partnership and excellent fringes.



Send detailed CV to:
Cathy Kortas
River Valley Medical Center
208 S. Adams St.
St. Croix Falls, WI 54024

WISCONSIN

MICHIGAN

IOWA

MINNESOTA

Great Lakes Great Life

Strelcheck and Associates, a respected search firm, invites you to consider a wide variety of group practice opportunities in the *Great Lakes Region*. Whether you prefer a metropolitan/suburban city, scenic college town, restful resort community, or something in-between, we have the setting for you! Many prominent groups and hospitals have come to rely on our professional approach to physician staffing. Call us toll-free at 800-243-4353 so we can earn your trust as well.



Strelcheck and Associates, Inc.
10624 N. Port Washington Road
Mequon, WI 53092

FAMILY PRACTICE HEMATOLOGY/ONCOLOGY PEDIATRICS
INTERNAL MEDICINE NEUROSURGERY NEPHROLOGY

COMPLIMENTS of Your Local Independently Owned Hospital Equipment and Supply Company serving Doctors, Nurses, Hospitals, Laboratories and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C.F.
anderson
COMPANY, INC.

and benefits are highly competitive. For additional information, contact Patrick Moylan at 612/932-5986, or send CV and letters of inquiry to Professional Practice Resources, Park Nicollet Clinic HealthSystem Minnesota, 3800 Park Nicollet Boulevard, Minneapolis, MN 55416; or Fax: 612/932-6490. 1-7/95

JULY 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Army Reserve	58
Aspen Medical Group	31
Blue Cross Blue Shield of Minnesota	2, 3
Central Minnesota Group Health Plan	61
C.F. Anderson Co., Inc.	63
Chisago Health Services	28
Coastal Physicians	60
East Range Clinics	60
Emergency Practice Associates	61
Fairview Clinic Services	46
Fargo Clinic MeritCare	27
Gillette Children's Hospital	28
HealthEast	Cover 4, 55
HealthPartners	27, 44
Health Risk Management	21
Leonard, Street & Deinard	21
Minnesota Medical Association	Cover 3
Minnesota Medical Business Resources	47, 51
Minnesota Physicians Insurance Agency	31
MMA Peer Review Consultation Services	32
Moonlight Home Health Care	61
Multicare Associates of the Twin Cities	56
National Car Rental System	16a
Navy Reserve Recruitment Command	62
North Memorial Medical Center	16
Oxboro Clinics	62
River Valley Medical Center	63
Sletto & Associates, P.A.	26
St. Francis, Inc.	62
St. Paul-Ramsey CME	50
Strelcheck & Associates, Inc.	63
Thunderbird Aviation, Inc.	28
University of Minnesota.	Cover 2
Whitesell Medical Locums, Ltd.	26








**THIS
PUBLICATION
AVAILABLE
FROM UMI**

This publication is available from UMI in one or more of the following formats:

- **In Microform**--from our collection of over 18,000 periodicals and 7,000 newspapers
- **In Paper**--by the article or full issues through UMI Article Clearinghouse
- **Electronically, on CD-ROM, online, and/or magnetic tape**--a broad range of ProQuest databases available, including abstract-and-index, ASCII full-text, and innovative full-image format

Call toll-free 800-521-0600, ext. 2888, for more information, or fill out the coupon below:

Name _____

Title _____

Company/Institution _____

Address _____

City/State/Zip _____

Phone () _____

I'm interested in the following title(s): _____

UMI 800-521-0600 toll-free
A Bell & Howell Company 313-761-1203 fax
Box 78
300 North Zeeb Road
Ann Arbor, MI 48106

St. Paul, Minnesota: BC/BE family physician to join a small suburban branch office of Ramsey Clinic—a 215-physician multispecialty group with affiliations with HealthPartners and St. Paul-Ramsey Medical Center—a regional tertiary care facility. The Maplewood office is a six-physician primary care clinic located in Maplewood, Minnesota, just 10 minutes from downtown St. Paul. At Ramsey Clinic-Maplewood, you can enjoy the practice style of a smaller practice, yet benefit from the professional and administrative support of our large multispecialty group. Opportunities to practice obstetrics or engage in teaching and research are optional. Send CV or contact: Karen Steiner, M.D., or Nancy Swenson, Manager, c/o Ramsey Clinic-Maplewood, 1774 Cope Avenue, Maplewood, MN 55109; 612/770-1497. 4-8/95

Pulmonary/ICU Medicine—Minneapolis: Two BC/BE pulmonary intensivists needed to join the five-person Pulmonary & Critical Care Medicine Department of a 385-physician multispecialty clinic and hospital medical system in the desirable Twin Cities area. Responsibilities include outpatient pulmonary medicine, inpatient pulmonary and critical care consultation, as well as teaching and supervision of critical care fellows and family practice residents. All technical facilities and professional medical personnel for a state-of-the-art practice are in place. Additional opportunities include sleep medicine, occupational lung disease, and invasive diagnostic and therapeutic procedures. Clinical research opportunities are available. Salary

Thank you!



Thank you for your MMA membership.

Your membership contributed to a successful 1995 legislative session. This year you helped achieve a number of victories for Minnesota physicians. Your involvement has won passage of the MinnesotaCare bill; major provisions include:

- Repeal of the regulated all payer option (RAPO)
- Inclusion of the MMA's data collection and utilization review provisions
- Repeal of the state's practice parameters committee
- Prohibition of the transfer of MinnesotaCare funds into the general fund
- Creation of a direct contracting pilot program for providers and purchasers.

You also reduced the felony penalty for criminal neglect in the Vulnerable Adults Act and kept the definition of criminal neglect and the penalty the same as in current law.

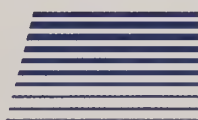
You passed the prompt pay bill requiring the Department of Human Services to pay provider bills on time or add an interest payment.

You passed a provision moving GAMC and Medicaid capitation rates toward geographic equity.

You defeated a provision that would have allowed managed care plans to discount provider fees below the workers' compensation fee schedule.

You defeated a provision to reduce physician reimbursement by \$5 for outpatient services in the MA program.

Details about these and a number of other successes for Minnesota physicians can be found in the June issue of *The Monitor* and *The Monitor In Brief*, or by contacting the MMA at 800-999-1875.



MMA

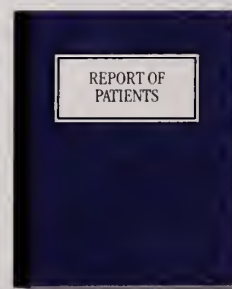
Minnesota Medical Association

WHEN TODD PETERSON PACKED HIS BAGS, HE LEFT SOMETHING BEHIND.



Todd Peterson became ventilator dependent following a traumatic motor vehicle accident. When Todd was deemed "unweanable" his family was told that he would live the rest of his life on a respirator. But so were Mrs. Moretti with chronic lung disease and Stephanie MacNeal battling a subarachnoid hemorrhage.

That's before HealthEast Bethesda Lutheran Hospital and Rehabilitation Center changed their lives. 30% of our patients considered unweanable were not only weaned, they packed up for home.



Call for our
white paper report and
updated statistics

Scope of services: General Medical Services • **Ventilator/Respiratory Care** • Wound Care
Neurobehavioral Services • Rehabilitation Inpatient Services • Swallowing Disorder Treatment
Capitol Heights Respiratory Residence • Geriatric Behavioral Care • Pain Management at
the **Minnesota Pain Center (MPC)**, located at HealthEast Bethesda Lutheran Hospital
and Rehabilitation Center, 559 Capitol Boulevard, St. Paul, MN 55103

For more information
Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

12977-41107
Univ. of Pittsburgh
Faikr. Library of the Health
Profession DA 15241-0001

00000000
C3D240C9
F64BF0F6
C0D2D267
10009140
02001198
020111AC
C0BC91C0

Prescription for Change

AUGUST 1995

WEBB FINANCIAL GROUP

INVESTMENT ADVISORS



LeAnn Lenander, CFP Les Webb Jerry Webb, CFP

Webb Financial Group has over 44 years in combined investment experience.

We are recognized as a leader in managing low to moderate risk
NO-LOAD FUND portfolios for individuals and retirement plans.

We primarily work with portfolios of \$200,000 or more.

Our mission is to help our clients achieve their investment and income objectives,
while maintaining a long term safe haven for their assets.

Call a personal investment advisor at
Webb Financial Group for a no-cost, no-obligation consultation.

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

AUG 10 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Jim Wilson.

FACE TO FACE

- 6** **INDISPENSABLE** William Hoffman
Hospitals and physicians increasingly are relying on the expertise of clinical pharmacists like Wendy St. Peter to help manage patients' care.

PERSPECTIVES

- 8** **SMALL-TOWN RACEWAY** Michael P. McCarthy, M.D.
A physician recalls the real-life nightmare of a senseless tragedy.

COVER STORY

- 10** **PRESCRIPTION FOR CHANGE** Miriam K. Feldman
Far more than pill counters, today's pharmacists say they should be providing patient counseling and care to optimize drug therapy.

PUBLIC HEALTH REPORTS

- 18** **IMMUNIZING THE ADULT IMMIGRANT PATIENT: WHAT TO DO WHEN THERE ARE NO RECORDS** Gregory A. Poland, M.D.
Immigrants to the United States often possess no immunization records and are at risk for contracting vaccine-preventable disease. Here are basic guidelines for bringing them up-to-date.
- 21** **VARICELLA VACCINE RECOMMENDATIONS** James Nordin, M.D., M.P.H.
National immunization committees are recommending wide use of the new chickenpox vaccine. Here's what you need to know.

CLINICAL & HEALTH AFFAIRS

- 25** **IMMUNIZATION COMPLIANCE OUTSIDE THE HEALTH PLANS: A NON-HMO REPORT CARD** Barbara P. Yawn, M.D., M.Sc., Margary Kurland, R.N., Ryan Boloton, and Allison R. Martin, M.H.A.

MEDICINE LAW & POLICY

- 41** **PHYSICIAN COLLECTIVE BARGAINING: ANTITRUST PROSPECTS AND PITFALLS** Bradley G. Clary, J.D.
Current options allowing competing physicians to collectively negotiate fees fall short of explicit immunity and leave physicians without complete protection.

33 *The* **Monitor**

HIGHLIGHTS ... Jacott re-elected to AMA board • AMA adopts Minnesota resolutions • AMA urges transformation of Medicare • Geographic coalition targets GPCIs

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 24 AUTHOR INSTRUCTIONS
- 49 NEWS CLIPS
- 57 CME IN MINNESOTA
- 59 CLASSIFIED ADS
- 64 INDEX TO ADVERTISERS

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical
Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.

Secretary
Thomas B. Dunkel, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Barbara P. Yawn, M.D.

Vice Speaker of the House
Anthony C. Jaspers, M.D.

Past President
C. Randall Nelms Jr., M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Charles S. Winjum, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.*
Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

**To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)**

© 1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

General Internist Opportunities

ReadyCare – Ramsey Clinic's urgent care facility, ReadyCare, offers patients convenient walk-in services and is supported by a comprehensive nurse triage system. A position is available for a general internist interested in working 20 hours per week or more. The position involves same day care and is flexible to include weekday or weekend hours, as well as possible additional hours in the Ramsey Clinic.

Health Center for Women – Our expanding Health Center for Women, a clinic focused on primary care for women from adolescence through geriatrics, has full and part-time staff positions available for internists with expertise in women's health. These positions involve one evening clinic – some hospital attending is preferred, but not required.

Ramsey Clinic – General internist opportunities are also available with the Ramsey Clinic or in combination with ReadyCare or Health Center for Women.

Board certified internists, forward your CV, including position preference (ReadyCare/Health Center for Women/Ramsey Clinic) to: **Sandy Lachman, Physician Services, Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. Or fax your CV to (612) 221-8571. EOE.**



HealthPartners
Ramsey Clinic

EMERGENCY MEDICINE P • S • I • T • I • O • N • S

IOWA

NORTH & CENTRAL MINNESOTA

- Full- and part-time
- Comprehensive benefit packages
- Paid malpractice
- Professional environments
- Ample time for family and leisure
- Progressive physician-owned group
- Excellent compensation packages
- Various locations
- Reasonable housing in safe communities
- Top-notch school systems
- Quality lifestyles

CALL 1-800 458-5003

Emergency Practice Associates
or send CV to Sheila Jorgensen
P.O. Box 1260, Waterloo, IA 50704

FAMILY PRACTICE OPPORTUNITIES Minneapolis/St. Paul

HealthPartners, Inc., offers excellent Family Practice opportunities for BC/BE Family Practitioners. HealthPartners, Inc., as a staff-model HMO, offers our physicians excellent salaries, generous benefits, a balanced lifestyle with practice scheduling flexibility and the opportunity to practice medicine without the headaches of managing an office.

The Family Practice Department is staffed by over 75 BC/BE physicians and offers a broad range of full-range and limited-range practice options.

To inquire about specific opportunities,

please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Inc., Physician Services, Attn: Ann Mliner, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

An EO/AA Employer.



HealthPartners

HealthPartner's mission is to improve the health of our members and our community.

A Winning Formula

New Model Expands Pharmacists' Role

Charles R. Meyer, M.D.

Health care today is like a biochemical reaction. The reactants are much the same as they were 10 years ago, but new catalysts have churned the mixture to a froth that emits previously undiscovered, sometimes toxic, vapors. The medical profession isn't the only reactant whose structure is changing. Like the drugs they study in school and dispense daily, pharmacists are undergoing a transformation. This month's *Minnesota Medicine* analyzes this change and what it means for pharmacists' co-reactants, physicians.

In our cover story, "Prescription for Change" (page 10), Miriam Feldman visits some local pharmacists and sees them contend with finicky formularies, miniscule margins, and receding respect. In our Face to Face article (page 6) William Hoffman profiles Wendy St. Peter, a Pharm.D. at Hennepin County Medical Center. Both articles chart pharmacists' transition from pill-counters to practice partners and from sundries sellers to health consultants. Partly as a response to declining reimbursement, the pharmacy profession is upgrading, building "new-model" pharmacists with new skills to sell. Whether third-party payers will recognize the value and buy remains to be seen.

What does this shift mean for physicians? For years, pharmacists have been the steady, quiet cryptographers who deciphered not only our scribbles but frequently our thoughts, reliably doling out our prescribed potions. Physician communication with pharmacists occurred primarily in brief hospital encounters over confusing orders, during quick telephone calls about illegible prescriptions, or through the daily barrage of prescription refill orders.



"Pharmacists will be active participants in the care of patients, educating doctors and counseling patients about the drugs dispensed."

Revamped pharmacists, as featured in our articles, will be active participants in the care of patients, educating doctors and counseling patients about the drugs dispensed.

Whether this new role will strike practicing physicians as help or hassle depends on how well pharmacists and doctors cooperate in building the model. No question, docs need help tracking the welter of new medications. Shelf-bending PDRs and weekly drug releases testify to the challenge of staying current with medications. No question, patients can benefit from more knowledge about their medications. Patients' familiar, "Oh, I stopped that one two weeks ago," and "It's the blue one," tell any doc that. But if the new pharmacy structure doesn't smoothly mesh with physician workflows, or if it means patients get different stories from the pharmacist than they

hear from their physicians, it will be more toxic than therapeutic. We need to coordinate our patient education and our care delivery.

Despite our mutual need, pharmacists and physicians have not communicated well in the past. We haven't talked to one another about how we do things at our respective ends of the phone. Until recently, we hadn't devised refill systems, prescription practices, and patient services that were mutually beneficial.

The plight of pharmacists and physicians is remarkably similar; we both contend with the invisible, hulking customers—the payers—lurking behind our tangible customers—the patients. We both face the clash of overhead and discounted fees. We both bridle at restrictive formularies. We both are visible symbols of health care costs, tangible humans who payers and patients must pay and, therefore, can blame for escalating prices.

Physicians and pharmacists should see one another as partners devising a new medical matrix that works. The "comprehensive pharmaceutical care model" referred to in Feldman's article should aim for a pharmacist-physician system that feels seamless to the patient.

Like any uninvited change, pharmacy's current metamorphosis might seem to physicians a needless, painful disruption of metabolic equilibrium. But if physicians and pharmacists bond together, the health care equation will yield greater therapeutic benefit for patients.

MM

INDISPENSABLE

William Hoffman

Life sometimes takes funny twists. As an undergraduate student at the University of Montana in Missoula in the late 1970s, Wendy St. Peter was majoring in microbiology when some pharmacy students talked her into switching to pharmacy. Years later, the person who had done most of the convincing became her husband and, ironically, one of her students in a Pharm.D. program. Today they work across the hall from each other at Hennepin County Medical Center (HCMC).

Wendy St. Peter, Pharm.D., is a clinical pharmacist at HCMC and an assistant professor of pharmacy at the University of Minnesota. Through her activities with the Drug Evaluation Unit and Caremark/RKDP (Regional Kidney Disease Program), she deals with patients directly every day. That is, she practices what people in the field call "pharmaceutical care."

As a member of the renal health care team, St. Peter meets daily with an attending physician, a nephrology fellow, medical residents, and nurse practitioners to discuss each patient's case. Pharmacy is represented on patient rounds by either a clinical pharmacist (St. Peter) or a Pharm.D. resident-in-training and a Pharm.D. student doing a month-long rotation to gain clinical experience.

Clinical pharmacists are now performing tasks that previously were the exclusive domain of physicians, such as evaluation of the appropriateness of prescribed medications. "It's very difficult, with the number of new, complex medicines being released, to keep track of everything—even for a pharmacist who has been specially trained, let alone for a physician who is expected also to know all the information on diagnosis and physical assessment of their patients," St. Peter says.

Is the blurring of boundaries between physicians' and pharmacists' duties a problem? Not in St. Peter's view, particularly not in an era of rapid change and managed care. "No one professional, whether a physician or pharmacist or nurse, can know it all. As we talk more about primary care and the need to emphasize evaluating the whole patient, the pharmacist really does become valuable because of our background and knowledge in the use of medicines," she says.

Caremark/RKDP dialysis units in Minnesota, South Dakota, and Wisconsin serve more than 800 hemodialysis and peritoneal dialysis patients. Acutely ill renal patients require the most sophisticated care. On average, those patients receive 12 prescribed medications.

"With additional years of education, you have the background and skills to clinically assess patients," says St. Peter, who has the traditional five-year bachelor of science degree, a two-year doctor of pharmacy degree, and a two-year post-Pharm.D. fellowship in adult medicine. "With the extra education and training gained through a Pharm.D. program, most people feel they can handle the added responsibility of taking care of patients. [Pharm.D.s] have

Hospitals and physicians increasingly are relying on the expertise of clinical pharmacists like Wendy St. Peter to help manage patients' care.

been quite successful at doing that—within the health care team approach.”

The pharmacist's expanding role in patient care is leading to a major shift in pharmacy education (see related story, page 10). Colleges of pharmacy across the country are going to six-year all-Pharm.D. programs and eliminating the traditional five-year bachelor of science in pharmacy. The University of Minnesota will offer only the Pharm.D.

degree beginning this fall. St. Peter says the Pharm.D. degree is necessary “to further educate pharmacists in patient care and in new and evolving technologies. It takes the extra education to turn the pharmacist from somebody who is dispensing a product into somebody who can work directly with the patient. I have always advised my students to get their Pharm.D. degree because I believe the extra knowledge and skills enhance patient care skills and ultimately benefit the patient.”

St. Peter's personal experience in the field parallels the changes in pharmacy education initiated when she was a college student, changes that correspond with the larger role pharmacists are assuming in many health care settings.

After she completed her bachelor's degree at Montana, St. Peter worked for a year in a hospital pharmacy in Texas, where her husband, John St. Peter, was serving in the Army. She then entered a two-year Pharm.D. program at the University of Texas in San Antonio and graduated in 1986. She completed a two-year fellowship in adult medicine to gain additional research and clinical experience.

ST. PETER continued on page 47



PHOTOGRAPH BY BRUCE BAIRD

Small-Town Raceway

Michael P. McCarthy, M.D.



ILLUSTRATION BY JOE HEFFRON



And so it starts
ominous death knell
amidst more pleasant sounds
of vernal awakening
Intrusive, grumbling, growling din
crescendos to a deafening roar

Our quiet little bedroom town
defies justification for it to be this way at all
windows rattle
china assumed safe in its hutch
shakes with indignation

Children cry and fuss well into the night
at pleasant slumber that will not stay
as incessant engines continue their roar
well beyond the witching hour

The 20-bed hospital here
nervously twitches
in anticipation of unwelcome tragedy
the pure horror of a memory unaged by years now past
keeps it fresh as yesterday:

The roof and his world
cave in around him as
he loses control, his car rolls
The disbelieving EMTs
drag him from the wreckage
and haul his mangled body in

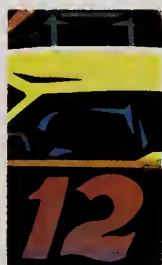
The family doc on call is summoned
painful drama fills the next two hours
and remains
a nightmare
that will forever haunt

IVs, intubation
Remember keep head and neck stable
as crushed occiput is constantly oozing
Staff hearts leap when his heart beats
V-fib to sinus rhythm

The chopper arrives and off he flies
from the hands of those who
with limited resources and experience
did the best they could

CTs later the call comes in:
transected brainstem
not a chance
futile efforts ...

What starts in spring ends in autumn
the final event of the year



a race to memorialize the race
that ended in such violence
and ended as his last
An event to honor him?
or to remind those who pay
the just rewards of fans back then
who saw what they had come to see and
with any bit of luck
might just happen once again

Michael McCarthy is a family physician currently specializing in occupational medicine with Mankato Clinic, Ltd., in Mankato, Minnesota. At the time of the fatal accident he writes about here, he was the on-call physician at Arlington Municipal Hospital in Arlington, Minnesota.

Prescription *for* Change

Far more than pill counters, today's pharmacists say they should be providing patient counseling and care to optimize drug therapy.



ILLUSTRATION BY JIM WILSON

When 45 community pharmacies closed in Minnesota last year, leaving the state with a net loss of 22, even close observers of the profession were caught off guard. “We realized it was a problem, but not to that point,” says Keith Pearson, director of the independent owner interest group for the Minnesota Pharmacists Association, which represents the state’s 1,700 pharmacists.

Yet Pearson’s own figures demonstrate why the number of closings shouldn’t have come as much of a surprise. In 1993, 20 percent of all pharmacies in the state operated at a loss. “Pharmacies are closing in geographically isolated

By Miriam K. Feldman

areas. They're busy, but there's no way to pay the bills. They're not being reimbursed correctly," says Pearson, who admits that his own pharmacy in Hibbing is not profitable. "The over-the-counters carry me through."

Profitable? Lowell Anderson, owner of Bel-Aire Pharmacy in White Bear Lake, netted \$2.50 on a \$400 prescription he filled last month. He relies on other merchandise to subsidize losses on the prescription side. "You have to be a very aggressive businessperson to stay alive; there's no value to the pharmacy anymore," says Anderson, who is past president of the Minnesota Pharmacists Association and recent past president of the American Pharmaceutical Association. He says people who invested in pharmacies hoping to use them as a retirement benefit have seen their retirement annuity disappear.

Over-the-counter medications. Greeting cards. Up-front merchandise. This is the stuff that can make or break a pharmacy. But pharmacists didn't spend years in school learning about disease states, drug interactions, and pathophysiology to end up counting pills and running a small retail business. Even those who manage to stay afloat are frustrated by their diminished professional role.

Today's pharmacists feel a loss of power and control. They feel squeezed by managed care and besieged by the conditions of third-party payers. Perhaps most important, they feel undervalued and unappreciated. They feel it when a longtime customer leaves for a store down the block that undersells a drug by \$2. And they feel it when the government attacks the drug industry. "When somebody speaks against the drug industry, in most patients' minds, that's also the pharmacy," says Anderson, who also holds an adjunct appointment in the University of Minnesota's Department of Pharmacy Practice. "Everybody seems to be against us."

And so, for the past five years, pharmacists here and around the country have been working to redefine the profession, in part for economic survival, but also because they believe there is a need for their services. Pharmacists want to reclaim their role in the community as trusted health care professionals who play a vital part in monitoring patient care. It's a role, they say, that has become increasingly important as drug therapy advances and the number of drugs proliferate. In their newly perceived role, pharmacists would work more closely with physicians; some even speak of themselves as physician extenders. In return, they are promising two big payoffs: better patient outcomes and cost savings.

"The way we deliver pharmaceutical services will be

vastly different," Anderson says. "Physicians will very shortly see a much more assertive pharmacist practitioner." If all goes according to plan, pharmacists will shift from pill counting to patient care. "If this doesn't work, there's no next alternative," Anderson says. "It's a last-ditch chance for the profession."

"It" is pharmaceutical care. "That's the big buzzword," says Don Uden, associate professor of pharmacy

**"You have to be a very aggressive
businessperson to stay alive; there's no
value to the pharmacy anymore."**

—LOWELL ANDERSON

practice in the University of Minnesota College of Pharmacy. While there are many different models of pharmaceutical care across the country, the one developed at the university is known as the comprehensive pharmaceutical care model. This particular model has been defined as "that component of pharmacy practice which entails the direct interaction of the pharmacist with the patient for the purpose of caring for that patient's drug-related needs." Under the model, pharmacists review patient records, do more patient education, monitor compliance, and check for adverse drug reactions.

Proponents of the pharmaceutical care model argue that such active involvement on the part of the pharmacist is long overdue. To make their case, they point to the literature on the human and economic toll of adverse reactions to prescribed drugs. For example, a *JAMA* report from the early 1970s stated that adverse drug reactions accounted for 140,000 deaths and 1 million hospital admissions in this country in 1971.¹ In 1987, the FDA recorded 12,000 deaths and 15,000 hospital admissions resulting from adverse drug reactions.² Even those numbers may be only a fraction—perhaps only 10 percent—of the total. Yet another study estimates that the cost of illness associated with prescription drugs in the United States is as much as \$7 billion a year.³

"We've identified a problem in health care delivery that exists and doesn't appear to be being addressed. That is, people are being hospitalized because of drug-related problems," says Pearson of the Minnesota Pharmacists Association. Pharmacists, like Pearson, believe

they have both the time and the skills to address that problem.

Drug therapy has become far more complicated since Pearson opened his pharmacy 17 years ago. "It isn't the same picture," he says. "There are categories of medications that didn't exist—calcium channel blockers, ACE inhibitors. You've got all sorts of biomedical types of genetically engineered drugs. Things that just were not available."

There's a good news-bad news twist associated with such advances. The good news, of course, is that improved drug therapies save lives and often eliminate the need for surgery. The bad news is, all these drugs increase the risk of adverse effects. Adverse reaction to a drug is

one problem. Patient compliance is another. Figures from Merck & Co. show, for example, that its drug Mevacor, used to treat high cholesterol, is taken appropriately only 15 percent of the time. And it is well-known that two-thirds of people on hypertension medications are noncompliant within three years.

Health plan drug formularies add another dimension to the problem. Each health plan has its own controlled list, or formulary, specifying the drugs for which it will reimburse patients. Of the almost 5,000 medications available in the United States, a formulary might include, for example, the 1,500 drugs that the health plan has deemed the most clinically effective and cost-effective for each drug class. The health plans distribute the formularies

to physicians so they can comply when prescribing medications. But physicians may be working under contract with multiple health plans, each with its own formulary. A typical 15-minute patient visit may not give the physician enough time to find the optimal, formulary-approved drug for a given patient—or to appeal to the health plan administrators if the best option is not on the list.

Pharmacists say they are in the best position to know if a prescription meets the formulary, since they are on-line with the claims adjudicators for every health plan. What's needed now, they say, is a way to work more closely with the physician's office in order to eliminate the confusion that arises over adherence to the formularies.

"There is a real need out there," Anderson says. "Nobody is answering the need. Pharmacists are an unused resource. We can solve a lot of the problems if we can be brought into the equation. Managed care has treated us like a warehouse. They have spent no efforts on truly managing drug therapy."

Pearson agrees. "I don't think pharmacists went to school to count by five to 100," he says. "That isn't what a pharmacist is trained to do." His remark takes on more importance for the next generation of pharmacists, most of whom will graduate with Pharm.D. degrees (see sidebar, page 13). Those

Patient Service Under Comprehensive Pharmaceutical Care

Patient consultation to discuss the patient's expectations and concerns about drug therapy, to evaluate the patient's understanding of drug therapy, to collect information from the patient, and to identify the patient's drug-related needs.

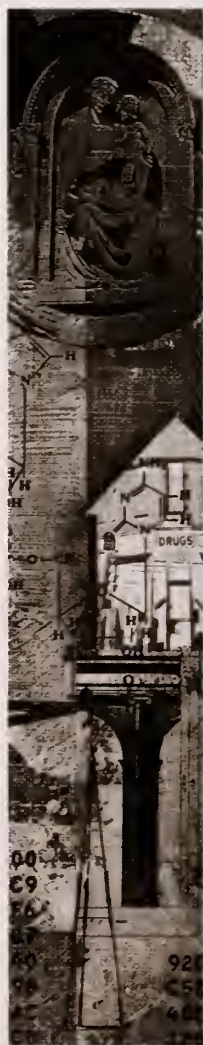
Pharmacist's assessment of the patient's entire drug therapy needs for the purpose of identifying current or potential drug therapy problems.

Creation of care plans to establish specific therapy goals, a monitoring schedule, and a written patient record, and to resolve current drug therapy problems and prevent others.

Patient education, recommendations, and referrals that will provide individualized, current information about the patient's drug therapy; give instructions for proper use of medications and related products; demonstrate special techniques or devices; and provide health and disease information.

Patient monitoring and follow-up at planned intervals to ensure that new drug therapy problems do not develop, therapeutic goals are being met, and actual patient outcomes are evaluated and documented.

Reprinted with permission from *American Pharmacy*, April 1995. ©1995 American Pharmaceutical Association.



'U' Training Pharmacists for the Future

Don Anderson, a retired pharmacist from the Paynesville area, has a daughter who recently received a Doctor of Pharmacy degree (Pharm.D.). "She doesn't even try to talk to me about [pharmacy]," Anderson says. "She goes way beyond me."

By the year 2000, pharmaceutical practice will be way beyond what many pharmacists have known. That's when the first crop of students will graduate from the University of Minnesota's new Pharm.D. program. Those students, who will enter the program this fall, will be the first group who won't have a choice between a B.S. and Pharm.D. degree.

The move to eliminate the B.S. degree programs in pharmacy is a trend occurring across the country. The change coincides with the profession's attempts to redefine itself. Pharmacists, who have been struggling to keep their practices economically viable, now are saying they want to assume a larger role in managing patient care. The Pharm.D. programs intend to prepare pharmacists to do so and to meet the new challenges of a changing profession.

"Tomorrow's pharmacists will all be clinically trained," explains Don Uden, associate professor of pharmacy practice in the College of Pharmacy at the University of Minnesota. "They'll have extensive educational backgrounds in disease states and how to treat disease states."

Pharm.D. programs are nothing new. Nearly 20 years ago, the University of Minnesota offered one of the first Pharm.D. programs in the country, enabling students to learn more about disease states, drugs, and pathophysiology. Nina M. Graves, interim associate dean in the College of Pharmacy, received her Pharm.D. degree from the university in 1979, when the class size was small enough that pharmacy students could join second-year medical students for instruction. By the early '80s, the College of Pharmacy had to develop its own courses to accommodate the growing number of students in the program. Now, Graves expects the college will admit between 80 to 100 students a year.

Although Pharm.D. programs have been around for a while, the move to an all-Pharm.D. program represents a shift in thinking within the profession. Currently, pharmacists are seen as gatekeepers, says Graves. They make sure prescriptions are correct

and call doctors when something seems wrong.

In the future, pharmacists will focus more on pharmaceutical care. They will look at every drug a patient is taking, help monitor for a desired outcome, and watch for drug-related problems.

"We've designed [the Pharm.D. program] to prepare pharmacists very well," Graves says. The biggest question is whether the program will turn out pharmacists able to meet medicine's needs, since health care is changing so rapidly. "I have no idea what medical life they will walk out into in 2000."

Lowell Anderson, who graduated from the College of Pharmacy in 1962 and served on a recent College of Pharmacy task force to evaluate the state's pharmacy needs, supports the switch to an all-Pharm.D. program. Pharmacists will be more competent in drug therapy management, he says. "When I went to school, the training was just drug product. Now, it's actually clinically based."

Still, the Pharm.D.-only concept has its critics. Willie LaCroix, chief executive officer of the Paynesville Area Health Care System, worries that rural communities may find it more difficult to hire pharmacists. "If all students in the future have gone to a Pharm.D. program and are only trained in the metro setting, who's going to come out to the Sauk Centres and the Marshalls and Redwood Falls and Paynesvilles? Who's going to provide those communities with pharmacists in the future?" he asks. "They're not going to want to come out and count pills."

LaCroix, in conjunction with Uden and Tom Larson, also of the College of Pharmacy, has established a program designed to recruit pharmacists to the Paynesville area. This year, a Pharm.D. graduate will work in the Paynesville Clinic on a fellowship program. LaCroix hopes she will be willing to stay on at the end of her fellowship, and he would like to find other students willing to take part in the program.

Advocates, meanwhile, say the move to the Pharm.D.-only program is long overdue. Uden believes pharmacists at last are fulfilling their rightful role as caregivers. "Now we'll have the manpower in terms of clinically trained pharmacists, through the Pharm.D. programs, to meet that demand."

—MKF

pharmacists are bound to feel undervalued unless they are allowed to play the more active role for which they will be trained.

"Now is the time to use the skills we've been given," says Uden, who has established a project at the Paynesville Clinic in Paynesville, Minnesota, that is a variation of the comprehensive care model. The project places a recent Pharm.D. graduate from the University of Minnesota at the clinic to work directly with patients who have diabetes, asthma, and hypertension. The clinic's six physicians will refer those patients to the pharmacist for education on the drug regimen and for follow-up visits. The pharmacist will help institute the therapy with the physician and also will monitor the dosage for possible adjustment and

check on compliance. If problems arise, the patient will be referred back to the physician.

Uden believes the arrangement will save time for physicians and will be especially beneficial in rural areas where there is a shortage of doctors. "It's very time intensive to do the educating and monitoring. You can't do it in a 15-minute visit," he says. "These clinics will be able to see more patients because a pharmacist is in there."

The Paynesville project "isn't new and novel, it's new and novel *here*," says Uden, who explains that Veterans Affairs and the Indian Health Service have been using pharmacists in a similar capacity for years.

Willie LaCroix, chief executive officer of the Paynesville Area Health Care System, which



Minnesota Leads the Way With a Pharmacist Network

When the American Pharmaceutical Association Board of Trustees recently authorized spending nearly \$500,000 to establish a program to advance the practice of pharmaceutical care, the organization's executive vice president acknowledged that the mission would be difficult. John A. Gans told a reporter for the organization's newsletter, "We have to get pharmacists thinking, 'How do I move from dispensing to providing effective patient counseling and care?'"

In Minnesota, pharmacists already have begun thinking about making that move. In fact, plans are in high gear to launch a network of community pharmacists who will be trained in practicing pharmaceutical care. When it's up and running, as many as 150 community pharmacists throughout the state are expected to be part of the Pharmaceutical Care Association (PCA Minnesota), a network that will specialize in providing patient counseling and care.

John Loch, owner of Loch Pharmacy in Rosemount, has been hired by PCMG, the management group that runs the network, to help other pharmacists make the transition from dispensing to patient care. Loch is one of about a dozen pharmacists who took part in a three-year pilot project called the Minnesota Pharmaceutical Care Project begun in

1992 by the University of Minnesota College of Pharmacy, the Minnesota Pharmacists Association, and the Minnesota State Board of Pharmacy to see what pharmaceutical care would look like in practice and how pharmacists would make the transition. PCA Minnesota has adopted the project's pharmaceutical care model.

The time is right for the changeover, Loch says. Right now, there is too much confusion in the writing and dispensing of prescriptions. Patients receive prescriptions from many doctors, and often fill them at different pharmacies. They buy drugs over the counter, and even through the mail, he explains. "We're trying to coordinate. We want to monitor and, where appropriate, follow up with the physician if there is a compliance problem or adverse effects." The goal is to prevent drug-therapy problems.

To make the transition from pill counter to caregiver, pharmacists who want to join the PCA network must take part in a 16-week training and accreditation program that involves both on-site training and a series of workshops. Pharmacists will be required to make changes in the pharmacy, such as turning over the dispensing work to technicians, establishing a separate, private area for patient con-

includes the Paynesville Clinic, says the clinic's physicians are receptive to the kind of help a pharmacist can offer. They welcome the option of referring patients to a Pharm.D., much like they refer them to a physical therapist.

Allan Solum, M.D., a family physician at the Paynesville Clinic, anticipates that having a pharmacist on site will free up some of his time. "I see this person as becoming a member of the health care team," he says. "[The Pharm.D.] is another resource for both physicians and patients. I see that person helping to manage patients' pharmaceuticals, particularly a patient on a multi-drug regimen."

Monitoring compliance will be another important role for the pharmacist, adds Solum. As a result, he predicts there may be fewer complications and better compliance.

sultations, and installing a computer system.

Pharmacists will be trained to ask the types of questions that could prevent drug-therapy problems. They also will learn to document all interactions with patients. At the end of 16 weeks, they will be required to pass a documenting test and a test of their cognitive skills to determine whether they are able to detect drug-therapy problems. Credentials will be issued by the Peters Institute of Pharmaceutical Care, the research and program development unit within the university's College of Pharmacy that conducted the pilot study.

PCMG is also establishing networks in Nebraska and Iowa and has been contacted by at least 20 other states. "We can't keep up with the number of states that want to join the network," says Loch.

The goal of all these efforts is cost saving and better patient care. "We believe that our network and the computerized capability of documenting patient care can bring savings to the health care system. We're selling the opportunity to access our network of pharmacists trained in pharmaceutical care," says John Peterson, chief executive officer of PCMG/PCA. "By doing things differently with the public, we can bring about savings of the health care dollar."

—MKF

That's exactly what the pharmacists are banking on, literally; they're hoping to make those things happen *and* to be reimbursed for it. Traditionally, pharmacists have been reimbursed for the cost of the drug product and for dispensing the medication, neither of which is enough to keep a pharmacy afloat.

Under managed care, pharmacists have seen the dispensing fee shrink, sometimes down to nothing. Pearson says a contract with a zero dispensing fee recently crossed his desk. Managed care groups, instead of the pharmacists, are setting the fees, and pharmacists who don't want to settle for reduced fees will see their business go elsewhere.

Payers feel justified in reducing the fee paid out for counting tablets and putting them in a bottle. In fact, much of the role of dispensing and filling already has been taken over by technicians. (Under the pharmaceutical care model, technicians would dispense orders, while the pharmacist would work in a separate area, meeting with patients for private consultations.)

But pharmacists aren't asking to be reimbursed more for dispensing. They want to be paid for the other services they provide. "We would probably still fill prescriptions for \$2.50," Anderson says. "Now we're saying that the pharmacist is going to manage the care of the patient. That will take time, and we'll be paid to manage this care."

As Pearson puts it: "My training was based in drug action, pharmacology, the physiology of the body. So we understood how the medications worked in the body. What [the new model] amounts to is being able to solve and identify drug-related problems. We do it all the time. The problem is, there wasn't a system developed to document what you did and how you did it."

The pharmaceutical care model provides that system by insisting on specific documentation of all the work done by the pharmacist on a patient's behalf. The \$64,000 question is, how much are those services worth? At this point, nobody knows for sure. A couple of research models suggest a reimbursement scheme based on the amount of time a pharmacist spends with the patient: the sicker the patient, the greater the reimbursement.

Ultimately, pharmacists hope to be paid on a capitated basis. But currently, there is no foundation for such a system. "How can you capitate if you don't know what [the service] is worth and what it costs?" asks John Loch, a Rosemount pharmacist who participated in the Minnesota Pharmaceutical Care Project, a pilot program that tested the delivery of this new kind of comprehensive care. Loch now trains other pharmacists who want to become part of a statewide network being organized by

Copayments Hide True Cost of Prescriptions

Despite cost increases that averaged 10 percent every year throughout the 1980s, consumers who had prescription drug insurance barely saw a blip register in the amount they had to pay at the pharmacist's window.

Thanks to a system in which an insurance patient's share of drug costs was limited to a copayment, the magic figure was typically \$7 per prescription. Although copayments have increased lately for some health plans, nearly one-half of Minnesota residents don't see the year-to-year markup because their insurance coverage insulates them from paying the true cost.

Or do they?

Members of health maintenance organizations (HMOs) and other managed care organizations indirectly pay for their medications through monthly premiums, of course, and HMOs have been working diligently to cut prescription drug costs to keep their fees down and retain members.

But a Minnesota Health Department study concluded that cash-paying customers might be paying more because retail pharmacists have been forced to raise prices to make up for lower reimbursement rates from managed care organizations.

Most affected are the uninsured and, because Medicare doesn't cover prescription drug costs, the elderly. In Minnesota, 49 percent of the senior population pays the full cost of their prescription drugs, a burden that is especially heavy considering that those older than 65 account for more than 25 percent of all prescription drug sales.

Costs of other products sold at independent pharmacies also might be higher. Whereas independent corner drugstores used to reap most of their profits from its pharmacy business, today many of them have to rely on sales of cards, candy, and gifts to stay in business.

Nearly 20 percent of all Minnesota community pharmacies registered a net loss in their pharmacy operations in 1991. Most affected have been the independent pharmacies, which lack the muscle to

negotiate prices with manufacturers. Between 1982 and 1992, there were 96 fewer independent pharmacies, and several have gone out of business since then. During the same period, 131 chain drug-store locations have opened in the state.

"Pharmacy is unlike any other business in the United States," says John Hoeschen, a pharmacist at Sundberg Pharmacy in St. Paul. "Chains are able to withstand the financial aspects of it a little longer because of size and financial structure and the way they market their products, but all community pharmacies

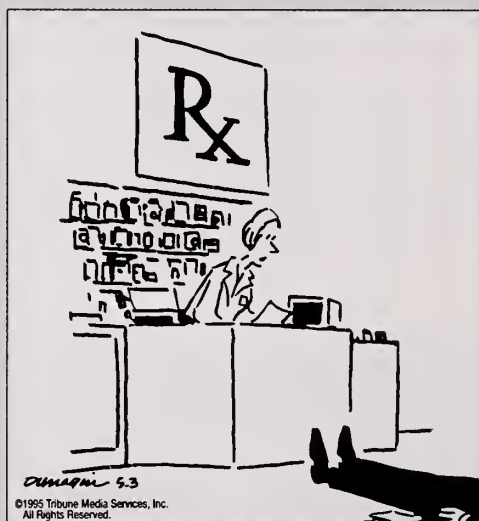
as a whole are hurting."

HMOs and pharmaceutical benefit management companies select certain drugs for their formularies, which is a list of medications that doctors choose from when writing prescriptions for patients. HMOs sometimes are able to negotiate rebates from drug manufacturers, especially when inclusion on the formulary can give the manufacturer more market share.

What irks independent pharmacists is that HMOs receive rebates based on the volume of prescriptions written to HMO members. HMOs use the rebates to lower their overall operating costs and keep premiums down.

But HMOs do not buy the drugs from the manufacturers; the pharmacy does. HMOs do reimburse pharmacists for the drugs their plan members buy, but the profit margin has gotten very narrow.

—Glenn Howatt



"Then perhaps the generic version ..."

Reprinted with permission from the Star Tribune, March 12, 1995. © 1995 Star Tribune.

a group called PCMG (Pharmaceutical Care Management Group). PCMG has hired an actuarial firm to assess the value of the services provided under the pharmaceutical care model (see sidebar, page 14).

If the goal is better quality of care, pharmacists say communication between physicians and pharmacists must improve. "There are going to be major practice changes for both of us," Anderson says. Pharmacists will have to learn to develop care plans for patients, and physicians will have to be available to take calls from pharmacists so that the plans may be carried out. "Physicians and pharmacists are going to have to talk directly with each other. I'm not sure physicians will see why it's necessary to take a pharmacist's call, but it can't be relayed through someone in the front office."

Pharmacists realize that physicians may feel imposed upon, even threatened, by this turn of events. But they insist that is not their intent. "It's so important that physicians not see the pharmaceutical care model as a threat," Anderson says. "We're not trying to do their job for them. We're trying to help them do their job better. It's going to require an increased level of collegiality."

Anderson adds that in pilot areas throughout the state, physicians have responded well to the change. "It's just a matter of understanding what it's all about. It's very consistent with physician goals."

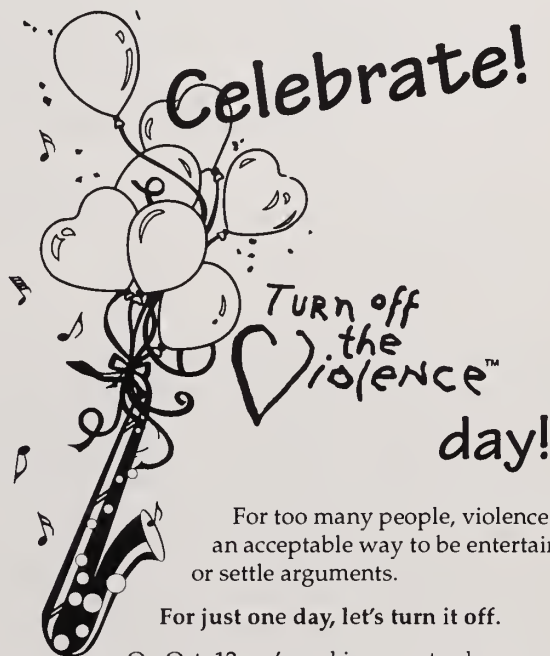
Pearson agrees: "The purpose is not to intercede and replace practitioners. The purpose is to make patients perform better on the therapy the doctor wants. If we can keep patients out of the hospital, away from the emergency room, in better control of their therapy, we've accomplished quite a bit."

MM

Miriam Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

REFERENCES

1. Talley RB, Laventurier MF. Drug-induced illness [Letter]. JAMA 1974;229:1043.
2. Manasse HR Jr. Medication use in an imperfect world: drug misadventuring as an issue of public policy, part 1. Am J Hosp Pharm 1989;46:929-44.
3. Manasse HR Jr. Medication use in an imperfect world: drug misadventuring as an issue of public policy, part 2. Am J Hosp Pharm 1989;46:1141-52.



For too many people, violence is an acceptable way to be entertained or settle arguments.

For just one day, let's turn it off.

On Oct. 12 we're asking you to choose nonviolent activities and tell us about them.

Ideas include:

- Turn off violent TV programs and music.
- Organize a family or community fun night.
- Solve problems in nonviolent ways.
- Display Turn Off the Violence brochures at your office.
- Come up with your own ideas and tell us about them!

Who will decide what's violent? You will. But look closely – we've been witnessing violence for so long we may not even recognize it as violence any more. And that's the problem.

Call 612/593-8041 to share your ideas, or write to us at:

Turn Off the Violence
P.O. Box 27558
Minneapolis, MN 55427

Citizens Council

Immunizing the Adult Immigrant Patient

What to Do When There Are No Records

Immigrants to the United States often possess no immunization records and are at risk for contracting vaccine-preventable disease. Here are basic guidelines for bringing them up-to-date.

Gregory A. Poland, M.D.

Editor's Note: This journal contains three articles on immunization: an immunization report card from a private group practice, an article on the newly approved varicella vaccine, and an update on immunizing adult immigrants. Few preventive health measures have been as successful as the basic immunization series of OPV, DTP, MMR, and Hib. It is important that children receive age-appropriate immunizations, i.e., shots given within two months of the date they are due, in order to protect them when they are most vulnerable to vaccine-preventable diseases. The report card (page 25) provides data about reasons for missed immunizations that may benefit your practice. Dr. James Nordin's article on Varivax (page 21) tells you why this new vaccine is a useful addition to our immunization armamentarium. And remember, immunizations aren't just kids' stuff. Dr. Gregory Poland provides guidelines in the following article to help unravel the mystery of immunizing Minnesota-bound immigrants. In Minnesota, more than 80% of all immunizations are provided by private medical groups. The immunity of Minnesota citizens to vaccine-preventable diseases depends on you.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

Adult patients born and raised outside the United States often have no written records or knowledge of their immunization status. The large influx of immigrants and refugees from Southeast Asia, the former Soviet Union, countries of Africa, and other areas of the world into Minnesota and the United States has increased the importance of taking a good immunization history, both because of immigrants' susceptibility to disease (hepatitis B in newborns and measles, for example) and the potential that immigrants might transmit vaccine-preventable diseases to U.S. citizens (such as vertical transmission resulting from chronic hepatitis B carriage). In light of the diverse groups entering Minnesota, physicians here will likely be making difficult immunization decisions concerning patients who have no immunization records.

Other countries, even other industrialized nations, have very different immunization schedules and recommendations than those in the United States. Vaccine recommendations in all countries, including the United States, are modified frequently based on the availability of new vaccines, the changing local epidemiology of diseases and risk factors, and evolving national priorities. To make matters worse, the very reasons behind an individual's decision to emigrate, such as war, famine, social disruption, or political unrest, often militate against having written medical records documenting what vaccines the patient received, at what dose, and at what intervals. Yet for every physician, the immunization history is integral to maintaining the health and well-being of the patient and his or her community. In fact, provision of vaccines is one of the most cost-effective measures physicians perform.

This article outlines general clinical guidelines to help physicians take an immigrant's history and make decisions about which patients to immunize and with what vaccines. Like all generalizations, these guidelines will not optimally cover all situations, but the alternative—delaying immunization while attempting to locate records or track down previous physicians—is more likely to lead to under-immunization.

GENERAL VACCINE GUIDELINES FOR ADULT IMMIGRANTS

Physicians should follow these basic vaccine guidelines:

1. Assume no vaccines have been given unless the patient has documented, written records that prove otherwise. A self-reported history (no written documentation) of previous vaccine doses should not be accepted.
2. Some individuals from developing countries have immunity resulting from wild virus exposure to hepatitis A and B, as well as measles, mumps, and rubella. Therefore, testing for immunity is an option. However, it is not a necessity, since immunization of an immune individual causes no more side effects than immunization of a non-immune individual.

Table

*Recommended immunization schedule for immigrant adults not immunized or of unknown immunization status**

Timing	Vaccines	Notes
First visit	Td	Three-dose primary series recommended for all adults, with a booster every 10 years.
	MMR	Persons born before 1957 considered immune to measles and mumps.
	Hepatitis B	Hepatitis B vaccine indicated primarily for adults with risk factors and no immunity.
	Influenza and Pneumococcal	Influenza and pneumococcal vaccines indicated for those with risk factors or >65 years of age.
	eIPV	Primary polio vaccination is not routinely needed, unless patient is under 18 or risk factors for exposure exist (i.e., traveling to an endemic area or returning to home country).
Second visit (4 to 8 weeks after first visit)	Td, MMR, Hepatitis B, eIPV	A second MMR may be indicated for certain adults at risk (see text).
Third visit (6 months after second visit)	Td, Hepatitis B, eIPV	
Additional visits	Td, Influenza	Td every 10 years throughout life. Influenza annually if high risk or >65 years of age.

*Please see publications 1-3 from resource list (page 20) for proper dosage and specific indications for immunization.

MMR: measles-mumps-rubella vaccine
eIPV: enhanced-potency inactivated polio vaccine
Td: tetanus-diphtheria vaccine (adult formulation)

3. If in doubt about immune status to a given antigen, test for immunity or immunize. In general, it is less expensive to provide a dose of vaccine than to test for immunity (hepatitis A and B immunity are notable exceptions). Do not indefinitely postpone immunizations in an attempt to locate medical records, because the patient may not return for immunization and, hence, will remain disease-susceptible. In particular, MMR, OPV, IPV, influenza, and hepatitis B vaccines have *not* been associated with adverse effects caused solely by repeated vaccine doses.

4. Suboptimal vaccines, inadequate maintenance of vaccines, and ineffective vaccine preparations are not uncommon in developing countries. The acceptability of vaccines given outside the United States depends on

adequate documentation of the specific vaccine given and whether the recommended age at immunization, dose, and spacing of doses is compatible with U.S. recommendations. If these criteria are not met, the validity of that immunization is called into question, and re-immunization or testing for immunity should be considered.

5. No vaccine series needs to be started over because too much time has elapsed since the last immunization. Simply continue with the series as if no extra time has elapsed. For example, hepatitis B vaccine is usually administered on a schedule of zero, one, and six months. If dose 2 was given four years ago, it is not necessary to start the series over; simply give dose 3 as if it were on time.

WHICH VACCINES SHOULD YOU CONSIDER?

Hepatitis B: A high percentage of adults from less-developed countries may already be immune to hepatitis B because the disease is endemic in many countries. In fact, persons from sub-Saharan Africa, Southwest and Southeast Asia, and China have a high likelihood of being chronic hepatitis B carriers and should be serologically screened (particularly women of child-bearing age). Knowledge of hepatitis B-carrier status has implications for providing medical advice and care to family

members and future children. If the patient is seronegative for hepatitis B-markers, then immunization may be appropriate, particularly if the individual plans to return to his or her home country. Otherwise, the indications for hepatitis B immunization are identical to those used normally in the United States.

Influenza: All individuals at increased risk for morbidity or mortality from influenza should be immunized annually. That includes those individuals with chronic cardiopulmonary disease, malignancy, immunodeficiency, and diabetes. Otherwise healthy individuals over 65 years of age also should routinely receive influenza vaccine. Remember, the influenza season in the Southern hemisphere is April to September, the *opposite* of ours. Therefore, individuals from the Southern hemisphere

who plan to visit their home country during that time and are eligible to receive the vaccine and didn't in the previous fall should be immunized.

Measles-Mumps-Rubella: All of these diseases have an increased risk of morbid complications in adults. In addition, foreign-born persons who visit their home countries may be exposed to vaccine-preventable diseases still rampant in many other parts of the world. In many countries, the single measles antigen is used rather than MMR. The options are to test for immunity (which should always be done in women of child-bearing age in the case of rubella), or simply give a single dose of MMR vaccine. A second dose is now recommended for all children, students pursuing postsecondary education, and health care workers. Pre-existing immunity is not a contraindication to the vaccine and does not lead to an increased rate of adverse reactions.

Polio: Fortunately, this disease has become less of a concern in North America. Immunization is not indicated unless exposure to polio is anticipated because of the patient's occupation, travel, or residence in an endemic community. The enhanced-potency inactivated polio vaccine (eIPV) is generally recommended for adults who have never previously received polio vaccine. This formulation carries no risks of vaccine-associated poliomyelitis.

Pneumococcal vaccine: This vaccine is rarely used outside the United States, even in other industrialized countries. Consequently, few if any adult immigrants will have received this vaccine. Anyone older than 2 years of age *who has risk factors* should be immunized. All adults over 65 years of age should routinely receive one dose of this 23-valent vaccine.

Tetanus-diphtheria: A three-dose primary series is required for immunity. Any dose of tetanus-diphtheria administered at more than 6 weeks of age can be considered valid. The first two doses of tetanus-diphtheria should be separated by a minimum of four weeks, and the third dose administered at least six months after the second dose, with booster doses every 10 years.

AN IMMUNIZATION SCHEDULE FOR THE UNDER-IMMUNIZED ADULT PATIENT

The table, page 19, gives health care providers an easy-to-use resource for coordinating multiple immunizations in under-immunized adults. General references are listed for additional information. By law, health care providers are required to ensure that the permanent medical record for each vaccine recipient states the dates vaccines were administered, the vaccine manufacturer, the vaccine lot number, and the name, address, and title of the person administering the vaccine.

CONCLUSION

The goals of this article are twofold: first, to raise awareness about immunizing adults who present without immunization records and, second, to offer reasonable guidelines to help the physician decide who needs immunization and with what vaccines. Situations will arise for which the advice presented here is insufficient

to make a decision. Vaccinologists can often help piece together information and guide the process because of their knowledge of other countries' vaccine schedules and their experience training people from these countries. Over-the-telephone advice is also readily available to physicians from the Minnesota Department of Health (612/623-5237 or 800/657-3723). In addition to answering questions, the Health Department can help translate foreign immunization records. MM

Gregory Poland is an associate professor of medicine in the Division of General Internal Medicine and director of the Vaccine Research Group, Mayo Clinic and Foundation, Rochester, Minnesota. He is also chair of the National Coalition for Adult Immunization.

RESOURCE PUBLICATIONS

1. ACP Task Force on Adult Immunization, Infectious Diseases Society of America. Guide for adult immunization. Philadelphia: American College of Physicians, 1994:1-218.
2. Centers for Disease Control and Prevention. General recommendations on immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP). Atlanta: Centers for Disease Control and Prevention, 1994. No. RR-1:RR-1-RR-38.
3. Plotkin SA, Mortimer EA Jr., eds. Vaccines. 2nd ed. Philadelphia: W.B. Saunders Co., 1994:1-996.
4. Geissler EM. Pocket guide to cultural assessment. Chicago: Mosby-Yearbook, Inc., 1994.*

*Geissler's pocket guide includes national childhood immunization schedules by country.



THUNDERBIRD AVIATION

FAA 141 APPROVED FLIGHT SCHOOL

GROUND & FLIGHT TRAINING FOR PRIVATE
• INSTRUMENT • COMMERCIAL • MULTIENGINE
• ATP • FLIGHT INSTRUCTOR



OVER 30 YEARS
EXPERIENCE
AREA'S LARGEST FLEET
OF PIPER AIRCRAFT

RENTAL - AIR CHARTER
AIRCRAFT SALES,
MAINTENANCE & FUEL SERVICE

941-1212

LEARN TO FLY

FLYING CLOUD AIRPORT, EDEN PRAIRIE

Varicella Vaccine Recommendations

National immunization committees are recommending wide use of the new chickenpox vaccine, Varivax. Here's what you need to know.

James Nordin, M.D., M.P.H.

After more than 10 years of clinical study, the U.S. Food and Drug Administration has licensed the country's first chickenpox vaccine for use in the United States. Manufactured by Merck & Co. under the trade name Varivax, the vaccine is being incorporated into the recommended childhood immunization schedule. It is 70% to 90% effective in preventing varicella (chickenpox) and could save the United States an estimated \$384 million annually in direct and indirect costs, including medical expenses and parents' lost wages, according to a study commissioned by the Centers for Disease Control and Prevention (CDC).¹

Chickenpox infects about 3.7 million Americans each year, primarily children under age 15. Each year it kills about 100 people and results in more than 9,000 hospitalizations. The vaccine could potentially eliminate chickenpox as an endemic disease.

VACCINATION RECOMMENDATIONS

The Redbook Committee of the American Academy of Pediatrics,² the American Academy of Family Practice, and the CDC's Advisory Committee on Immunization Practice (ACIP) recommend that this vaccine be widely used. This article briefly summarizes their recommendations.

The varicella vaccination should not be given to children under age 1. Universal infant vaccination at 12 months to 18 months of age is recommended. Currently, the vaccine cannot be given in the same syringe as MMR. That could complicate the 15-month visit, when three (or four) shots are recommended. However, varicella vaccination and MMR may be administered from different syringes at the same visit. Any child seen between 12 months and 15 months of age for any reason should be given the chickenpox vaccine at that visit unless contraindicated (see below).

A one-shot catch-up program for *nonimmune* children age 18 months through 12 years is recommended. For *nonimmune* patients age 13 and older, including adults, a two-shot catch-up program with shots given one to two months apart is recommended. If the series is

interrupted, it does not need to be restarted, only completed.

EFFECTIVENESS

For immunized children with household exposure, the varicella attack rate is 25%, as compared with 90% for unimmunized children. The effectiveness rate is 72% (Merck, unpublished data). More important, however, the vaccine is more than 95% effective in preventing severe disease (>300 lesions and a fever). With natural exposure, i.e., exposure in the community, a 1% to 2% annual breakthrough rate occurs in vaccinated children.

CONTRAINDICATIONS

This vaccine has numerous contraindications, including most immune-compromised states and pregnancy (see table, page 22). However, a research protocol using this vaccine is available for children with acute lymphocytic leukemia, and these patients should be considered for enrollment in the study.

Chickenpox virus is teratogenic.³ It causes fetal varicella syndrome in about 2% of infections in pregnant women. The risk of the vaccine in pregnancy is unknown. Thus, pregnancy is an absolute contraindication.

The most conservative approach regarding pregnancy is to test all female patients between menarche and menopause for pregnancy on the day each dose of the vaccine is given. A more moderate approach is to test all women age 13 and older. At the other extreme is to simply ask women whether they are or could be pregnant. Less conservative approaches are expected to become more appropriate as experience is gained with this vaccine.

Physicians who elect to test all menstruating female patients for pregnancy should initiate a process to handle positive pregnancy tests effectively and confidentially. If patients are simply asked whether they are or could be pregnant, some pregnant women will likely be given this vaccine, with unknown risk.

Table

Indications and contraindications for varicella vaccination with Variavax

- Indications**
- Give routinely to children 12 months to 18 months of age. Cannot be given in the same syringe as MMR
 - Give one dose to all nonimmune children older than 18 months and under 13 years whenever they are seen
 - Give two doses one to two months apart to all nonimmune patients age 13 years and older
 - Consider testing for immunity all historically nonimmune patients age 13 and older

Contraindications

- Pregnancy
- Immune-compromised state
 - Congenital immune deficiency
 - Blood dyscrasias
 - Lymphoma
 - HIV (symptomatic or asymptomatic)
 - Acute lymphocytic leukemia (but see text)
 - First-degree relative of person with congenital immune deficiency (until immunodeficiency is excluded in patient)
- Receiving steroids (the following doses are as measured in prednisone)
 - 2 mg/kg/day or greater for patients less than 22 pounds or
 - 20 mg/day or greater for patients 22 pounds or more
- Previous anaphylactic reaction to neomycin
- Administration of immune globulin in the past five months
- Moderate or severe intercurrent illnesses (not including URI, diarrhea, or otitis media)

Non-contraindications

- Presence of a pregnant woman in the family or household
- Presence of an immune-compromised patient in the family
- Where chronic salicylate use is necessary, it is probably less risky to immunize than to risk infection with the wild virus

Nonimmune children and adults living with a pregnant woman *should* be vaccinated. Fetal varicella syndrome is far less likely if susceptible children in the family are immunized, because this decreases the pregnant woman's risk of contact with the wild virus.

HISTORICAL NONIMMUNES

Seventy percent to 90% of adults who believe they are nonimmune actually are immune when tested with a commercially available ELISA test.⁴ One small study series suggests that virtually everyone over age 35 is immune.⁵

In patients who require two injections, a strong argument can be made for testing titers before immunizing. If 80% of patients age 13 and older are, in fact, immune, the advantages of testing are enormous. The average number of visits to the clinic and needle sticks

per patient drops from two for a universal immunization program to 1.2 for a screen-first program. For most health care provider organizations, testing titers of historically nonimmune patients will be cost-effective. The average cost of the titer test is about \$10 to \$15, whereas two varicella immunizations cost about \$80.

PERMANENCE OF IMMUNITY

Of necessity, all studies of the vaccine so far have been done under endemic conditions. Thus, wild virus exposure has likely been boosting immunity, and it has been impossible to determine the duration of immunity attributable just to the vaccine. Long-term studies are under way to test the duration of immunity following vaccination.

COST

This is an expensive vaccine that should be covered by health plan contracts. It is cost-effective for employers, with at least twice the investment returned in the form of decreased employee absenteeism. When the next round of contract negotiations occur between employers and health plans, the cost of this vaccine should be covered. In the meantime, patients, physicians, and managed care organizations must absorb the extra cost.

COMMENTARY

The stated goal of the varicella vaccine program is to eliminate chickenpox as an endemic disease. However, we must guard against a poorly executed immunization program that allows chickenpox to become an epidemic disease instead. In this scenario, chickenpox epidemics would occasionally sweep through the nonimmune

population, causing a higher rate of morbidity and perhaps mortality because the disease burden would likely shift to an older cohort.⁶

When assessing only the medical costs, varicella vaccine costs about \$2,500 per year of life saved, far less than most medical interventions. The vaccine becomes highly cost-effective when the cost of lost wages and sick time are included. Working parents, especially, will reap the benefits and will likely generate great demand for the vaccine.

MM

James Nordin is a general pediatrician at the HealthPartners St. Paul Clinic and a clinical associate professor in the Department of Pediatrics, University of Minnesota Medical School. He has conducted clinical studies of measles vaccination, pertussis disease epidemiology, immunization practices, and lead poisoning in children.

He is chair of the Institute for Clinical Systems Integration (ICSI) Pediatric Immunization Guideline Work Group, chief author of the guideline, a member of the Minnesota Department of Health Immunization Practices Committee, and co-chair of the HMO Council Immunization Action Task Force.

RESOURCES

1. The "ICSI Childhood Immunization Guideline Addendum on Chickenpox" is available from the Institute for Clinical Systems Integration by sending a self-addressed, stamped envelope to ICSI, 8009 34th Avenue South, Suite 1155, Bloomington, MN 55425.
2. Patients with acute lymphocytic leukemia should contact the Varivax Coordinating Center, Bio-Pharm Clinical Services, Inc., 4 Valley Square, Blue Bell, PA 19422; 215/283-0897.
3. Report suspected adverse reactions to the Vaccine Adverse Event Reporting System (VAERS) program, 800/822-7967.

REFERENCES

1. Lieu TA, Cochi SL, Black SB, et al. Cost-effectiveness of a routine varicella vaccination program for U.S. children. *JAMA* 1994;271:375-7.
2. AAP Committee on Infectious Diseases. Recommendations for the use of live attenuated varicella vaccine. *Pediatrics* 1995;95:791-6.
3. Enders G, Miller E, Cradock-Watson J, Bolley I, Ridehalgh M. Consequences of varicella and herpes zoster in pregnancy: prospective study of 1,739 cases. *Lancet* 1994;343(8912):1548-51.
4. Kelly PW, Petrucci BP, Stehr-Green P, Erickson RL, Mason CJ. The susceptibility of young adult Americans to vaccine-preventable infections: a national serosurvey of U.S. Army recruits. *JAMA* 1991;266:2724-9.
5. McKinney WP, Horowitz MM, Barroila RJ. Susceptibility of hospital-based health care personnel to varicella-zoster virus infections. *Am J Infect Control* 1989;17:26-30.
6. Halloran ME, Cochi SL, Lieu TA, Wharton M, Fehrs L. Theoretical epidemiologic and morbidity effects of routine varicella immunization of preschool children in the United States. *Am J Epidemiol* 1994;140(2):81-104.

URGENT CARE OPPORTUNITIES

HealthPartners, Inc.

HealthPartners, Inc., is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24-hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according

to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Inc., Physician Services, Attn: Ann Mliner, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.

An EO/AA Employer.



HealthPartners

HealthPartner's mission is to improve the health of our members and our community.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Immunization Compliance Outside the Health Plans

A Non-HMO Report Card

Barbara P. Yawn, M.D., M.Sc., Margary Kurland, R.N., Ryan Boloton, and Allison R. Martin, M.H.A.

ABSTRACT

Purpose: To assess the rate of completed immunizations by age 24 months in children cared for by a private medical practice.

Methods: A chart review of all children born between January 1, 1990, and June 30, 1992, and seen by a provider in this private medical practice at least once between ages 15 months and 24 months.

Results: Overall, 77% of children received four DTP immunizations, 78% received at least three OPV immunizations, and 82% at least one MMR by 24 months of age. Seventy-two percent received the recommended combination of one MMR, three OPV, and four DTP immunizations by age 2. Rates were about 5% to 10% higher in children delivered by physicians of the group practice where the study occurred. The presence of a serious medical problem did not statistically significantly change the rates of completed immunizations. The rate of missed opportunities was almost three times as high in those not completing the basic DTP, OPV, MMR immunization series by age 24 months.

Conclusions: Rates of immunizations are high in this private group practice and comparable to those reported by HMOs that care exclusively for children with insurance. However, the rate of missed opportunities is also high, with three to four visits for each child who did not complete the basic immunization series by age 24 months. This private practice report card will be used to improve immunization practices in our medical group.

The immunization of children against diphtheria, tetanus, pertussis, and polio is a major public health goal for our country¹—a goal that remains unattained. By school entry, almost 98% of children are adequately immunized,² but measuring the rate of completed immunizations in school-age children is measuring too late; this is not an acceptable assessment of protection for our children. Immunization rates by age 24 months have become the standard.³ One major problem stands in our way: We do not know at a national, state, or county level which children aged 24 months and under have been immunized. In fact, few practices can assess their own rates of immunizations. Without a universal system, planning methods to improve immunization rates are based on studies and HMO report cards.

A recent Minnesota Department of Health report card of immunization rates in a subgroup of Minnesota children up to age 24 months served continuously by Minnesota's five HMOs reported rates of basic immunization completion from 75% to 95% by age 2.⁴ Even with these high rates, only two of the five HMOs in the report meet the Healthy People 2000 goal of 90% immunization by age 24 months.³

Having health plan- or practice-specific data is necessary to quantify a practice's strengths and weaknesses and evaluate the effect of programs implemented to improve immunization rates. The purpose of this study was to identify recorded immunization rates in a private non-HMO group practice. In addition, the rates and types of visits that were missed opportunities for immunizations are reported. Finally, the physicians' perceptions of immunization rates in the practice and reasons for

missed opportunities are compared with the study results. By presenting more detailed information than is contained in the usual "report card," the process of improving the immunization rates can be facilitated.

METHODS

This is a retrospective cohort study that includes all children seen at least once at the Olmsted Medical Group (OMG) between ages 15 months and 24 months and born between January 1, 1990, and June 30, 1992. Data were collected in July and August 1994, more than two years after the birth of the youngest child included in the cohort.

SETTING

OMG is a multispecialty group of 65 physicians that includes five full-time equivalent pediatricians and seven FTE family physicians in the main (Rochester) office where the study was done. The group has a walk-in immunization clinic that allows children to come for immunizations at any time and gives immunizations based on all available immunization records and on the parents' or providers' requests. The community is also served by a larger health care facility, a public health nursing clinic that provides well-baby care, and an immunization clinic.

DATA COLLECTION

We reviewed all in-house medical records of a cohort of all children born from January 1, 1990, through June 30, 1992, for any documentation of immunizations. The cohort included all children whose births were supervised by a physician at the Olmsted Medical Group plus all other children seen at least once at OMG between ages 15 months and 2 years.

Information collected from these

children's charts included dates of all immunizations given at the Olmsted Medical Group or recorded as given at any site. Dates of immunizations recorded from copies of parents' immunization records, outside medical records, and care summary letters from other providers were also abstracted. In addition, we recorded all comments from the chart and correspondence that stated "child being immunized elsewhere" or "immunizations up to date." However, only immunizations with specific dates recorded were counted as known immunizations and incorporated into the rates of completed immunizations.

Other information abstracted from the chart included date of last visit if the child left Olmsted Medical

Group before age 2, the dates of all missed opportunities for immunizations in any child past due for an immunization, and the reason for the "missed opportunity" visit. A visit was considered a "missed opportunity" if a child was more than one month beyond the age recommended by the Centers for Disease Control and Prevention (CDC) using the 1993 immunization schedule for any DTP, OPV, or MMR in the initial series; had not had the immunization; and did not have a temperature of 102° F either recorded at that time in the office or recorded in the history of current illness. Office visits that resulted in hospitalization within five days were not considered "missed opportunities." Hib and HBV were not included in the definition of missed opportunity since the CDC modified the recommended timing of these immunizations during the course of this study.

Delayed immunizations were defined as follows: 1) first DTP and OPV later than three months; 2) second DTP and OPV later than five months; 3) third DTP later than seven months; 4) fourth DTP later than 19 months; 5) third OPV later than 19 months; or 6) first MMR later than 19 months.

We also recorded serious chronic medical conditions identified between birth and 2 years. We recorded only chronic medical conditions that were likely to extend beyond childhood, that might have long-term sequelae, or that have ever been considered a contraindication to immunizations. For example, recurrent otitis media and asthma were not considered "serious medical conditions." Seizure disorder (other than febrile seizure), leukemia and other malignancies, congenital heart disease requiring medical or surgical intervention, meningitis with resulting neurological damage, and immune-deficiency conditions were considered serious

chronic medical conditions.

The definition of adequate immunization was three DTPs, four OPVs, and one MMR by age 24 months. Analyses including one and two Hib vaccinations and one, two, and three HBV vaccinations are included by year of the child's birth. The suggested immunization schedule given to parents at well-child visits is presented in Table 1 to serve as a standard for comparison. Denominators for the percent of children appropriately immunized at any age include the children who had been seen at the Olmsted Medical Group at least once prior to or at the age of assessed immunization status and had not, to our knowledge, left the community.

Since Olmsted Medical Group is not an HMO, no measures of continuous enrollment are possible. Therefore, children whose birth was supervised by an OMG physician and who visited OMG at or after 18 months of age were considered to be under "continuous care" of OMG.

To gather information on the physicians' perception of immunization at OMG and their beliefs regarding reasons for delayed immunizations, we surveyed all family physicians and pediatricians.

DATA ANALYSIS

Simple statistics were calculated for each of the DTP, OPV, MMR, Hib, and HBV immunizations. These included percent of children receiving each immunization at the recommended time, i.e., first DTP at 2 months of age $\pm$ 2 weeks, stratified by site of birth; the percent of children receiving combinations of immunizations at recommended times (DTP, OPV, and MMR); and the percent of children completing all recommended immunizations by age 2. Data were also stratified by presence or absence of serious chronic disease, such as seizure disorder or congenital heart disease. Chi-square tests were used to compare proportions of children with immunizations based on site of birth and disease status.

Rates of completed immunization series were calculated using only the basic DTP, OPV, and MMR immunizations by age 24 months. Chil-

Table 1

Child health maintenance schedule (1991 version)

Well-child exams	Immunizations
Birth	HBV
1-2 Weeks	None
1 Month*	None
2 Months	DTP, OPV, Hib, HBV
4 Months	DTP, OPV, Hib
6 Months	DTP, Hib
10 Months	TB test, HBV
15 Months	MMR, DTP, OPV, Hib
2 Years	None
3 Years	Blood test, urine
5 Years	DTP, OPV, TB test
12 Years	MMR
15 Years	Td—and every 10 years thereafter

*Visit optional

Table 2

Number of DTPs by site of birth and presence of 'serious' medical problems

No. of DTPs	Site						Medical problems	
	All N=1258		OMG N=887		Other N=371		All with "serious"	
	n	(%)	n	(%)	n	(%)	n	(%)
at least 4	970	77.1	744	83.9 [†]	220	59.2 [†]	44	72.0
at least 3	1,048	83.3	812	91.5 [†]	254	68.5 [†]	49	80.3
at least 2	1,078	85.7	831	93.7 [†]	265	71.3 [†]	50	81.9
at least 1	1,206	95.9 [*]	847	95.5 [†]	285	76.8 [†]	53	86.9
none	52	4.1 [*]	40	4.5 [†]	86	23.1 [†]	8	13.1 [*]

Data were missing for approximately six children and are not included in the analysis.

^{*}p<.05[†]p<.01

dren's data were censored at the time they left the community and denominators appropriately adjusted. The rates were stratified by the child's site of birth and the rates compared using Chi-square statistics.

In addition, we calculated the timing and frequency of missed opportunities, as well as the type of visits considered missed opportunities for children with and without completed immunization series.

RESULTS

Overall, 72% of the 1,258 children in the cohort who were still in Rochester at 18 months of age received all immunizations in the basic series by age 24 months, and 96% received at least one immunization by age 24 months. Only two charts recorded parental refusal to accept any immunizations. The completed immunization rates were statistically significantly higher for the 904 children whose births were supervised by OMG physicians, as compared with the 354 born at another facility, 79.2% vs. 53.9% (p<.001).

The rates of completed immunization did not vary significantly when

stratified by birth year. The presence of a "serious" medical problem *did* decrease the rate of completed immunizations by age 24 months to 63.5%. However, the number of children with serious medical conditions is too small for stratification by site of birth (OMG vs. non-OMG).

The completion rate for immunizations when Hib and HBV were included is lower, approximately 58%. However, the recommended schedule for Hib and the recommended use of HBV changed markedly during the course of the study, and no further analysis of vaccine combinations including Hib and HBV was done. No child who remained entirely unimmunized at 4 months of age completed the vaccination schedule by 24 months.

DTP

Table 2 lists the percent of all children who had one to four DTPs recorded. Children born and followed at Olmsted Medical Group were more likely to have three or four DTPs by age 24 months than those children not born under the care of OMG physicians. The rate of children who

completed four DTPs by age 24 months did *not* vary by the birth year of the child. The presence of a serious medical condition did *not* affect the rates of DTP immunization. Children who completed the DTP series by age 2 were more likely to have started their DTP shots by age 2 months (89% vs 74%, p<.01).

OPV

Table 3 presents the rates of OPV immunizations by number of immunizations recorded and the presence of a serious medical condition. As with DTP, the immunization rates of OPV vaccination for OMG-born children is higher at all levels. The presence of "serious" medical problems did *not* adversely affect the rate of immunization. Again, children who began immunizations at the recommended time were more likely to complete the OPV series by age 24 months (89% vs 70%, p<.01).

MMR

The single MMR recommended by age 24 months was recorded in 82% of children overall but statistically significantly more often in those chil-

Table 3

Number of OPVs by site of usual care and serious medical problems

	Site						Medical problems	
No. of OPVs	All N=1258		OMG N=887		Other N=371		All with "serious" N=61	
	n	(%)	n	(%)	n	(%)	n	(%)
at least 3	977	77.7	752	84.8 [†]	223	60.1 [†]	43	70.7
at least 2	1,098	87.3	834	94.0 [†]	262	70.5 [†]	48	78.7
at least 1	1,140	90.6	852	96.1 [†]	286	77.1 [†]	53	86.9
none	118	9.4	35	3.9 [†]	85	22.9 [†]	8	13.1

Data were missing for approximately six children and are not included in the analysis.

^{*}p<.05[†]p<.01

Table 4

MMR by age 24 months by source of usual medical care and presence of serious medical problems

	Site						Medical problems	
No. of MMRs	All N=1258		OMG N=887		Other N=371		All with "serious" N=61	
	n	(%)	n	(%)	n	(%)	n	(%)
At least 1	1,032	82.0	773	87.1 [†]	256	69.0 [†]	47	75.8
None	226	18.0	114	12.9 [†]	115	31.0 [†]	14	24.2

Data were missing for approximately six children and are not included in the analysis.

^{*}p<.05[†]p<.01

dren born at OMG than those not born at OMG. The presence of a serious medical problem did *not* affect the overall reported rate of MMR immunization. The exact percent of MMR immunizations is presented in Table 4.

Hib

The rate of either one or two Hib vaccinations increased for children

born in later years. For those born in 1989 and '90, the rate of one Hib by age 24 months was 64% and 65%, respectively. For those born in 1991, the percent of Hib vaccination jumped to 77%, and it was 93% in those born in the first six months of 1992.

HBV

Overall, only 44% of children in the cohort had three HBV immuniza-

tions by age 24 months. However, the percent increased significantly with later year of birth. The percent increased from 0% for those born in 1989 to 25% in 1990 and up to 58% for those born in 1991. Those born at Olmsted Medical Group were more than twice as likely to have any HBV immunization recorded ($p<.001$) and about 1.5 times as likely to have three HBVs by 1991 and 1992 ($p<.02$).

MISSED OPPORTUNITIES

Table 5 compares the numbers and types of missed opportunities in children who did and did not complete the basic immunization series by age 24 months. The rates of missed opportunities are statistically significantly higher in children who did not complete the basic immunization series ($p < .001$); all of these children had at least one missed opportunity. Only 59% of those who completed the basic immunizations by age 24 months had at least one missed opportunity. Sick-child visits are by far the most common types of missed opportunities in both groups. A small but significant number of well-child visits are also recorded as missed opportunities.

PHYSICIAN SURVEY

Physicians were asked in a survey to estimate the percentage of children seen in their practices who are immunized by age 24 months (only DTP, OPV, and MMR were considered) and to state what they thought were the major reasons for "missed opportunities." Of the 26 surveys sent, 24 were returned. Estimates of the rate of completed immunizations by age 24 months ranged from 50% to 95%, mean 84%, median 85%. Only one physician gave an estimate of less than 75%. That physician is one of the newest to OMG and may have a patient population that is less well established and, therefore, more likely to include children seen primarily for urgent or sick care.

The reasons the physicians gave for "missed opportunities" are listed in Table 6. These physicians agree with the information in the literature that both parents and physicians are reluctant to give ill children an immunization even when it is not "contraindicated."

DISCUSSION

The 72% of children who had a completed (and recorded) basic immunization series by age 2 compares favorably with the Minnesota state rate of 61.4%⁵ and the Olmsted County rate of 75% calculated from retrospective surveys of school-age children.⁴ The 79.2% rate of comple-

Table 5

Number of missed opportunities by completed immunization status

Shot status	All missed opportunities*	Sick-child visits	Well-child visits	Follow-up visits	"Other" visits
Complete n=905	395	330	38	23	4
Not complete n=353	1,163	1,000	42	84	37

*Children often had more than one type of missed opportunity.

Table 6

Most common physician responses to: "What do you think are the most common reasons for 'missed opportunities' "? (Check all that apply.) Twenty-four physicians responded.

No.	Reason
20	Parents or physician reluctant to give ill child immunization.
12	Parents don't want shots when child not in for well-baby check.
16	No adequate reminder system of needed immunizations.
12	Physicians too busy dealing with illness or symptoms of child.
21	Physicians/nurses don't ask if child needs shot if child is receiving part/most of care elsewhere.
12	Physicians just are too busy in general to think of everything.
15	Parent wants shot given somewhere else.
7	Parents don't want to wait for the shot that day.
16	Parent or child going out of town/has important event and wants to delay shot.
3	Cost is too high.
7	Lack of up-to-date shot records.
1	Parents don't take responsibility.

Note: Physicians estimated that 59% of all children with incomplete immunizations by 24 months had at least one missed opportunity.

tion in children born under supervision of Olmsted Medical Group physicians and followed at least once between age 15 months and 24

months compares favorably with most of the reported rates of immunization in children continuously enrolled in Minneapolis HMOs.⁴

Children enrolled in HMOs are fully insured for all immunizations. They are, therefore, not totally comparable to the cohort of children born under the supervision of and cared for at least once between ages 15 months and 24 months by an OMG physician. It may be the closest approximation that is available but certainly favors the HMOs for assuring financial access to care.

The rates reported in this study are the rates of immunizations recorded in the medical record at a single site and are likely to be lower than the true rates, since many children receive care and, potentially, immunizations from multiple sources. Previous studies from Rochester estimate that more than 90% of children in the "study community" seek medical care from multiple sources during the first two years of life. Although Olmsted County has the unique opportunity to pool data from all medical records through the Rochester Epidemiology Project, we did not collect data from any records

other than the single practice site. Most community practices do not have the capacity to obtain records from multiple immunization sites. Therefore, we used only the data that were available to the physicians in the medical records from the single site. The availability of a national, state, regional, or even local tracking system would undoubtedly increase the rate of completely immunized children in this cohort.⁶

The 79% rate of immunization completion is below the 85% mean immunization rate estimated by the OMG physicians. This may be because physicians know more about immunizations than they record or, more likely, they tend to inflate perceived rates of compliance with preventive health care measures. The rate of 96% of all children followed at OMG having at least one immunization in the first two years is similar to the 90% quoted by Cutts for all U.S. children.⁷

The number of missed opportunities was very high for children with

inadequate immunization; this confirms the findings of others that children with greater numbers of missed opportunities are more likely to be inadequately immunized.^{2,8} The number of missed opportunities during sick visits for children with fevers of less than 102° F and no hospitalization is particularly high. These missed opportunities may reflect the reluctance of the physician or the parents to immunize an ill child. The surveyed physicians expressed some reluctance to immunize an ill child with any fever but said that much of the reluctance was due to parental concerns. Greater awareness of the 1992 standards for immunization practice and its simple table of contraindications (Table 7) may help parents, physicians, and nurses reduce the number of missed opportunities.⁹ No physician mentioned malpractice concerns as a reason to delay a child's vaccination.

Physicians listed the lack of a reminder system and the complexity of the immunization schedules as other factors associated with "missed opportunities." Reminder systems for providers, parents, and parent educators have met with varying success.¹⁰⁻¹³ The Centers for Disease Control and Prevention in conjunction with the American Academy of Pediatrics and the American Academy of Family Practice has just released a new "simplified" version of the immunization schedule (Table 8). The new schedule calls for more immunizations to be given at a single visit and moves the third OPV to age 6 months. It remains to be seen whether this new simplified version, which includes two Hib and three HBV shots, will increase the rate of immunization compliance in 24-month-olds.^{14,15} The impact of adding yet another immunization, varicella, remains to be measured (see page 21 for more information on the new varicella vaccination).

Beginning immunizations early was important in our cohort. No child who remained unimmunized at 4 months was completely immunized by 2 years. This confirms Freed's earlier observation that children who were completely immunized by age 2 were statistically significantly more

Table 7

*Contraindication to immunizations**

DPT	• Moderate or severe illness, not mild illness • Previous anaphylactic reaction to this vaccine • Previous encephalopathy within seven days after DTP • Undiagnosed progressive neurologic problem • Precautions (not absolute contraindications): – Temperature of 105° F or more within 48 hours after previous DTP – Convulsion within three days of previous DTP – Continuous crying lasting three or more hours after previous DTP
OPV	• Moderate or severe illness, not mild illness • Previous anaphylactic reaction to this vaccine • Cancer, leukemia, lymphoma, immunodeficiency or HIV • Immunosuppression—anti-Ca drug or steroids • Someone in the household who is immunosuppressed (can use IPV when immunosuppression is a concern) • Pregnancy, unless immediate protection is needed, then use OPV
MMR	• Moderate or severe illness • Previous anaphylactic reaction to this vaccine • Pregnancy now or possible within three months • Anaphylactic reaction to eggs or neomycin • Cancer, leukemia, lymphoma, or immunosuppression (HIV is not a contraindication) • Immunosuppression from drugs, i.e., anti-Co or steroids

*Reproduced from Immunization Action Coalition, May 1995, adapted from approved statements by the ACIP, AAP, and AAFP.

Table 8

Recommended childhood immunization schedule United States—January 1995*

Note: This schedule is provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, it cannot substitute for the clinical judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, it reflects the best understanding of the science of medicine at the time of publication, but it should be used with the clear understanding that continued research may result in new knowledge and recommendations.

Age Vaccine ▼	Birth	2 mos	4 mos	6 mos	12 ⁵ mos	15 mos	18 mos	4 - 6 yrs	11-12 yrs	14-16 yrs
Hepatitis B ¹	HB-1									
		HB-2		HB-3						
Diphtheria, Tetanus, Pertussis ²		DTP	DTP	DTP	DTP or DTaP at 15+ m			DTP or DTaP	Td	
<i>H. influenzae</i> type b ³		Hib	Hib	Hib	Hib					
Polio		OPV	OPV	OPV				OPV		
Measles, Mumps, Rubella ⁴					MMR			MMR or	MMR	

* Vaccines are listed under the routinely recommended ages. Shaded bars indicate range of acceptable ages for vaccination.

¹ Infants born to HBsAg-negative mothers should receive the second dose of Hepatitis B vaccine between 1 and 4 months of age, provided at least 1 month has elapsed since receipt of the first dose. The third dose is recommended between 6 and 18 months of age.

Infants born to HBsAg-positive mothers should receive immunoprophylaxis for hepatitis B with 0.5 mL Hepatitis B Immune Globulin (HBIG) within 12 hours of birth, and 0.5 mL of either Merck Sharpe & Dohme vaccine (Recombivax HB) or of SmithKline Beecham vaccine (Engerix-B) at a separate site. In these infants, the second dose of vaccine is recommended at 1 month of age and the third dose at 6 months of age. All pregnant women should be screened for HBsAg in an early prenatal visit.

² The fourth dose of DTP may be administered as early as 12 months of age, provided at least 6 months have elapsed since DTP3. Combined DTP-Hib products may be used when these two vaccines are to be administered simultaneously. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for use for the 4th and/or 5th dose of DTP vaccine in children 15 months of age or older and may be preferred for these doses in children in this age group.

³ Three *H influenzae* type b conjugate vaccines are available for use in infants: HbOC [HibTITER] (Lederle Praxys); PRP-T [ActHIB; OmniHIB] (Pasteur Mérieux, distributed by SmithKline Beecham; Connaught); and PRP-OMP [PedvaxHIB] (Merck Sharp & Dohme). Children who have received PRP-OMP at 2 and 4 months of age do not require a dose at 6 months of age. After the primary infant Hib conjugate vaccine series is completed, any licensed Hib conjugate vaccine may be used as a booster dose at age 12 to 15 months.

⁴ The second dose of MMR vaccine should be administered EITHER at 4 to 6 years of age OR at 11 to 12 years of age.

⁵ Vaccines recommended in the second year of life (12 to 15 months of age) may be given at either one or two visits.

Approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

likely to receive all immunizations within a month of the recommended time.²

Although the rate of recorded immunizations is higher than reported state and county rates, it does not meet the 90% immunization goal of the U.S. Department of Health and Human Services³ or the professional goals of Olmsted Medical Group. These data are being used to identify system, personal, personnel, and professional barriers to immunizations in young children. OMG is participating in a pilot program to develop a county-wide immunization track-

ing system, as well as better internal reminder systems. Physician, nurse, and parent educational programs are also planned. The rate of immunizations will be reassessed in two years to see whether it has improved. Such an internal system of assessment, targeted practice revisions, and reassessment are consistent with total quality management and physician-directed practice improvement that should be the outcome of all report cards.

MM

ACKNOWLEDGMENT

The authors appreciate the secretari-

al support of Kelly Madsen and the medical records support of the Department of Medical Records of the Olmsted Medical Group. This study was funded by the Olmsted Medical and Health Care Foundation.

Barbara Yawn is a family physician and director of clinical research at the Olmsted Medical Group in Rochester, Minnesota. Margary Kurland is a nurse abstracter and research associate and Ryan Boloton was a student summer intern in the Department of Research at Olmsted Medical Group. Allison Martin is a re-



Pediatrician

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 160 professionals who offer care at 13 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

search assistant in the Department of Epidemiology, Merck Research Labs in West Point, Pennsylvania.

If you would like to do a similar study in your office, new software is available at no charge from the Minnesota Department of Health. You must collect and enter the data into the program, but it will do the calculations. Data also can be imported from other immunization programs already in use. For information, contact Margo Roddy at 612/623-5372 or Kris Ehresmann at 612/623-5707 and ask about the CASA program.

REFERENCES

1. Zylke JW. Declining childhood immunization rates becoming cause for concern. *JAMA* 1991;266:1321.
2. Freed GL, Bordley WC, Defriese GH. Childhood immunization programs: an analysis of policy issues. *Milbank Q* 1993;71:65-96.
3. United States Department of Health and Human Services. Healthy People 2000: national health promotion and disease prevention objectives. Washington, D.C.: Public Health Services, 1990.
4. Minnesota Department of Health. 1993 HMO operations in Minnesota. St. Paul, Minnesota: Occupational and Systems Compliance Division, Minnesota Department of Health, October 1994.
5. Anderson TA. Medicine for a sick immunization system. *Minn Med* 1993; 75(5): 23-5.
6. Williams BC, Miller CA. Preventive health care for young children: findings from a 10-country study and directions for United States Policy. *Pediatrics* 1992;89(Suppl.): 983-9.
7. Cutts F, Zell E, Mason D, Bernier R, Din E, Orenstein W. Monitoring progress toward U.S. preschool immunization goals. *JAMA* 1992;267:1952-5.
8. Centers for Disease Control. Standards for pediatric immunization practices. Atlanta: Department of Health and Human Services, 1992.
9. United States Department of Health and Human Services. Standards for pediatric immunization practices: recommended by the National Vaccine Advisory Committee, April 1992, approved by the United States Health Service, May 1992, endorsed by the American Academy of Pediatrics, May 1992. Washington, D.C.: Public Health Service, 1992.
10. Oeffinger KC, Roaten SP, Hitchcock MA, Oeffinger PK. The effect of patient education on pediatric immunization. *J Fam Pract* 1992;35(3):288-93.
11. Clayton FW, Hicksaw GB, Miller CS. Parents' responses to vaccine information pamphlets. *Pediatrics* 1994;93:369-72.
12. Melman ST, Kaplan JM, Caloustain ML, Wemberger JA, Smith J, Cenbor RD. Readability of the childhood immunization information forms. *Archives of Pediatrics and Adolescent Medicine* 1994;148:642-4.
13. Szilagui PG, Rodwald LE, Souagram J, Yoos L, Doone C. Improving influenza vaccine ratio in children with asthma. *Pediatrics* 1992;90:871-5.
14. Dietz VJ, Stevemount, Zell ER, Cochi S, Hodler S, Eddins D. Potential impact on vaccination coverage levels by administering vaccine simultaneously and reducing dropout rates. *Archives of Pediatrics and Adolescent Medicine* 1994;148:943-9.
15. Madlon-Kay DJ, Harper PG. Too many shots? parent, nurse and physician attitudes toward multiple simultaneous childhood vaccinations. *Archives of Family Medicine* 1994;3:610-3.

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree™

Minneapolis 667-0705

©1995 Norwest Bank Minnesota N.A.
Member FDIC

ANNOUNCEMENTS

.....

**COME TO ROCHESTER FOR THE
1995 MMA ANNUAL
MEETING, SEPTEMBER 27-
29, 1995**

...

NEW PROGRAM HELPS PHYSICIANS SURVIVE A PROFESSIONAL LIABILITY LAWSUIT

The Minnesota Physicians Foundation has introduced a new program—the Physicians Litigation Support Program—to help physicians deal with the stress caused by a professional liability claim or lawsuit. “We want physicians to know they are not alone,” said Stephen Hadley, M.D., member of the Physicians Litigation Support Program Committee. “Other physicians have gone through this experience and have felt the same disbelief, frustration, and isolation. They are willing to help.” The program refers participants to a peer who has faced a professional liability claim and who can offer support. The peer support network gives participants an opportunity to talk about their experience in a confidential, informal setting. A packet of helpful articles and information on coping strategies is also available.

For more information, call Katherine Kennedy or Pat Biersach, Minnesota Physicians Litigation Support Program, 612/362-3761 or 800/999-1875.

The Monitor

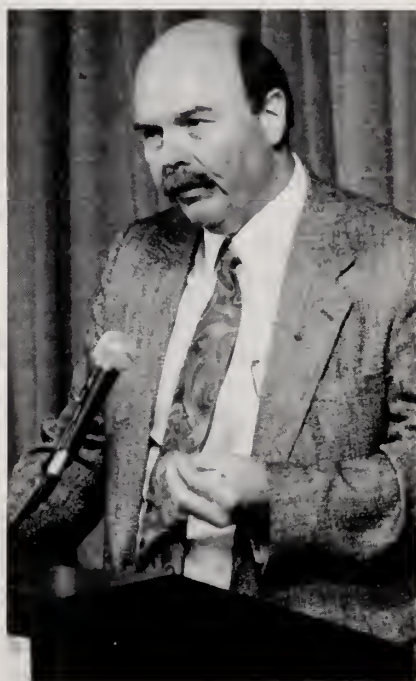
NEWS FOR MINNESOTA PHYSICIANS

Bill Is Back—Jacott Wins Re-Election at AMA

William E. Jacott, M.D., was re-elected to the American Medical Association Board of Trustees at the AMA Annual Meeting June 17-20 in Chicago. A family physician, Jacott is associate professor at the University of Minnesota and associate provost for the University's Academic Health Center. He was first elected to the AMA Board in 1989 and was re-elected in 1992. While on the board, he has served as secretary-treasurer and as vice-chair.

“I am delighted to be re-elected to my third term on the board,” Jacott told *The Monitor*. “As we move through the coming year, the most important initiative will be the restructuring of Medicare with all of its ramifications including professional liability reform, antitrust relief, and physician work-force issues.”

Jacott chairs the AMA delegation to the Joint Commission on the Accreditation of Healthcare Organizations. He is the AMA representative to the Board of the American Association for the Accreditation of Laboratory Animal Care and its past chair. In addition, he represents the AMA Board of Trustees on the Medical Outcomes Trust, the National Association for Biomedical Research, and on the Accreditation Council for Continuing Medical Education. He has represented the AMA before medical societies, business organizations, labor unions, seniors' organizations, the news media, and Congress. He also serves on the boards of the Health Education and Research Foundation, chairs the Park Nicollet Medical

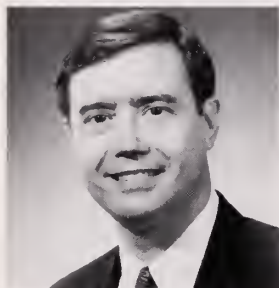


Foundation Board, and is a member of the Rotary Club.

Jacott has also served on the Minnesota Board of Medical Practice and as president of the Federation of State Medical Boards. He was awarded the MMA Distinguished Service Award in 1991.

Jacott was nominated and sponsored by the Minnesota Medical Association and endorsed by the North Central Medical Conference, the American Academy of Family Physicians, and the AMA Section on Medical Schools. His successful re-election campaign was chaired by A. Stuart Hanson, M.D., chair of the Minnesota delegation to the AMA.

.....



Viewpoint

• • •

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

It's 'Back to the Drawing Board' for State Programs

When was the last time you heard a colleague say: "Gosh, I really love working with the Medical Assistance program. The state pays in a timely fashion and, like all state programs, it works very efficiently"?

If you answered, "Never," you'll probably agree there is room for improvement in the way the state funds and administers its programs.

We physicians may soon have an opportunity to help design such improvements. The national focus has shifted from health care reform to budget cuts, sending the states scrambling to come up with ways to cope with the expected loss of federal funds. Minnesota is exploring plans to restructure its programs to make them leaner and more efficient.

Physicians must be involved in developing these plans to deliver medical services to our most vulnerable patients. We have many concerns about state programs. Most importantly, we want to make sure the state retains a safety net for the needy rather than relying on cost shifting to the private sector to pay for their medical care. We are also concerned about determining eligibility, being paid in a timely fashion, and receiving fair reimbursement for our services. We object to the 2 percent provider tax to fund the MinnesotaCare program and to the \$400

surcharge on our medical license that is designed to draw matching Medicaid money from the federal government.

While the current system is far from perfect, the future promises to be even more daunting. To balance the federal budget by the year 2002, Congress has proposed cutting \$182 billion from the Medicaid program over the next seven years and converting it to a block-grant program. For Minnesota this would mean \$400 million to \$500 million less per year for the Medical Assistance (MA) program.

Clearly, the state will have to find ways to do more with less. Planning is already underway. The governor has set up a task force, chaired by Vin Weber and John Brandl, to develop a restructuring plan that he hopes will correct rather than manage the state's structural deficit.

Physicians must be in on the ground floor as this new system is built. Floor plans must include a fair financing mechanism for state programs. There must be broad-based, public funding to care for low-income Minnesotans and to assure that provider reimbursement for state programs does not lag far behind standard fees. Methods to determine eligibility and benefit levels must be streamlined.

The state also should address the geographic inequities in the capitated MA program. Currently, rural

physicians in capitated MA programs are paid less than their urban counterparts. Last session, the MMA convinced the Legislature to pass a law that will narrow the gap, requiring the non-metropolitan capitation rate to be 85 percent of the urban rate. The new law also calls for an advisory group to develop capitation rates based on appropriate criteria rather than on historical charges. This is a step in the right direction.

Since a great deal of MA money goes to pay for long-term care, the state should improve the appropriate use and efficiency of long-term care. Efforts are underway. The Minnesota Health Care Commission is studying methods to control acute and long-term care costs. The Department of Human Services has created the Long-Term Care Options Project to integrate nursing home care and acute medical care for people who are eligible for both Medicare and MA. This voluntary project will combine Medicare and MA funds and set a flat capitated rate for both programs. Planners also are talking about ways to encourage people to buy long-term care insurance.

Several other solutions to the state's budget problems are under consideration. Proposals range from mandatory managed care to vouchers to direct contracting to reimbursement cuts. The Minnesota Medical Association is studying the pros and cons of various options. Physicians should be in the forefront of making these plans, which will have a powerful impact on us and on our patients. Money won't necessarily solve structural problems. We will have to think creatively to come up with solutions that will work in a much more constrained economic environment.

How involved should the MMA be in developing policies for restructuring state programs? We would have to devote a considerable amount of our resources to develop solutions to the complex problems of financing and delivering state programs. Should this be an MMA priority in the coming year? Let me know what you think.

• • • • •

AMA Adopts Minnesota Resolutions

The Minnesota delegation introduced three resolutions, which were warmly received by the American Medical Association House of Delegates at the AMA Annual Meeting.

Resolution 105, Ambulatory Patient Groups

This resolution was placed on the consent calendar and adopted. As a result, the AMA will study the implications of ambulatory patient groups (APGs) and report back to the AMA House of Delegates at the 1995 Interim Meeting. This resolution was triggered by the Health Care Financing Administration's recommendation to Congress that Medicare begin phasing in APGs for payment of hospital outpatient surgical, diagnostic, and radiology services. Under APGs, a bundled payment covers all facility, technical, and supply costs for an outpatient visit. This replaces a facility payment to the hospital in addition to the provider payment.

Resolution 205, Criminalization of Health Care Decision-Making

The AMA House of Delegates adopted a substitute resolution that includes and strengthens the Minnesota delegation's Resolution 205, which called on the AMA to oppose the criminalization of medicine, to report to the House, and to educate the public. Compelling testimony before AMA Reference Committee B highlighted the current trend toward criminalizing medical decisions that lead to bad outcomes. A striking example of this trend is the conviction of a New York City physician for reckless endangerment and willful violation of health laws after he made a medical decision that the prosecutor claimed led to a patient's death. The physician was sentenced to 52 weekends at Rikers Island. Substitute Resolution 202, adopted in lieu of Resolutions 205 and 202, asks the AMA to take the following actions:

- Oppose the attempted criminalization of health care decision-making, especially the current trend toward criminalization of malpractice. It interferes with appropriate decision-making and is a disservice to the American public.

- Develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including the criminalization of cases involving allegations of medical malpractice.

- Implement an action plan for all components of the Federation to educate opinion leaders, elected officials, and the media about the detrimental effects of criminalizing health care decision-making.

Resolution 229, Interpreter/Translator Services

The AMA House adopted this resolution, which calls on the AMA to take the following actions:

- Study federal and state legal requirements for the provision of qualified medical interpreters/translators;

- Work with appropriate government agencies to develop a definition for "qualified medical interpreter;"

- If appropriate, develop model legislation to clarify the physician's responsibility to make interpreter services available and to establish a payment mechanism separate from reimbursement for office visits;

- Report to the House of Delegates at the 1995 Interim Meeting.

This resolution responds to several problems raised by the need for interpreter or translator services. Physicians have a duty to make sure their patients understand information about their medical care. But there is no nationally accepted definition of a "qualified medical interpreter," and physicians may be unable to assess an interpreter's qualifications. Inadequate interpretation of medical information could lead to misunderstanding, lack of proper informed consent, and liability for negligence. In addition, physicians who do not supply or pay for a non-English-speaking patient's interpreter risk losing federal funding for both Medicare and Medicaid patients. There is no mechanism that would allow a physician to request third-party reimbursement for hiring a medical interpreter. • • • • •

Minnesota Physicians Are Prominent in AMA



At the AMA Annual Meeting, A. Stuart Hanson, M.D., chaired AMA Reference Committee B, which dealt with legislative affairs.

Richard B. Tompkins, M.D., chaired the Minnesota delegation to the AMA. Robert D. Christensen, M.D., served on Reference Committee E, which dealt with issues related to science and technology. Other Minnesota AMA delegates include E. Duane Engstrom, M.D., Audrey M. Nelson, M.D., Ben P. Owens, M.D., and Thomas A. Stolee, M.D. Alternate delegates are Theodore L. Fritsche, M.D., Frank J. Indihar, M.D., Carolyn J. McKay, M.D., Lyle Munneke, M.D., C. Randall Nelms, M.D., Bruce A. Norback, M.D., and Thomas L. Peyla, M.D. • • • • •

ANNOUNCEMENTS

• • • • •

**THE MINNESOTA MEDICAL
ASSOCIATION ANNOUNCES
THE FOURTH ANNUAL
CONFERENCE FOR PLANNERS
OF CME**

October 20, 1995
The Sheraton Inn Midway
400 North Hamline Avenue
St. Paul, MN 55104

The MMA Committee on Accreditation and Continuing Medical Education (CME) invites everyone involved in CME planning to its Fourth Annual Conference. Topics for the day-long conference include a review of the Essentials and Standards with a chance to share practical tips and planning forms; pointers on joint sponsorship; and a comparison of the various CME credit systems. Expect to have fun exploring the latest in tele-education, participating in a live demonstration on using the Internet for CME, and playing "CME Jeopardy." There also will be time to meet informally with other CME planners. For more information, or to register, call Jane Phillip, 612/378-1875 or 800/999-1875.

The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for 6.0 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Geographic Coalition Targets GPCIs

The Geographic Coalition met June 19 in Chicago to discuss ways to respond to proposed cuts in Medicare growth. The coalition brings together states that share the goal of eliminating gross disparities in Medicare reimbursement based on location. Minnesota physicians are reimbursed less for the same service than physicians in many other parts of the country—a situation that may become worse as Medicare funds are slashed.

More than 50 physicians, representing 22 of the 35 states in the coalition, attended the meeting, which was chaired by MMA President Andrew J.K. Smith, M. D. The coalition discussed the possibility of working to achieve single Medicare payment districts within states and eliminating or improving the geographic practice cost index (GPCI) that adjusts Medicare payment based upon the location of the practice.

The coalition was cofounded by the Minnesota Medical Association and the Utah Medical Association in 1989 to urge Congress to correct geographic disparities in Medicare reimbursement. When Medicare payment was restructured in 1992, the resource based relative value scale (RBRVS) system was expected to be more fair to Minnesota and other states at the bottom of the reimbursement barrel. But although the RBRVS system reduced geographic inequities, it did not eliminate them.

Despite objections from the coalition, a geographic practice cost index (GPCI) was developed to adjust the RBRVS payment to reflect the varying cost of practicing medicine in different regions. The coalition criticizes the GPCIs, charging that the extent of variation is excessive and the wrong data is used to calculate them. Most importantly, at a time when the budget crunch makes efficiency vital, the GPCIs punish efforts to practice cost-effective medicine. The question is: How do you

adjust Medicare payment to reflect actual regional differences without penalizing efforts to be more efficient? The Geographic Coalition will be wrestling with this question in the weeks ahead.

Geographic Inequities Continue Under GPCIs

Here are some examples of the way GPCIs affect physician payments in different areas.

Surgical Code

For a gallbladder removal, code 47605, Medicare reimbursement before it is adjusted by the 1996 GPCIs is \$844.95. In Minnesota, the 1996 GPCI would lower this amount to \$801.14, while in Manhattan, New York, the GPCI would raise the payment to \$1,041.13. Minnesota would receive 94.8 percent of the unadjusted Medicare rate, while Manhattan would receive 123.2 percent.

Nonsurgical Code

The differences are not so dramatic for an office visit. For an office visit by an established patient, 99211, the unadjusted fee is \$13.83. In Minnesota the 1996 GPCI would lower the fee to \$13.23, while in Manhattan, it would raise it to \$17.29. Minnesota would receive 95.7 percent of the unadjusted Medicare rate, while Manhattan would receive 125 percent.

Make Every State a Single District?

At the request of Minnesota physicians, Minnesota was designated a single Medicare payment district. But in other states, Medicare reimbursement varies widely depending on location. Texas has 32 different payment districts, California has 28, Illinois 16, and Wisconsin 11. The coalition is considering the possibility of advocating single Medicare payment districts to reduce the variations within states.

Coalition continued on page 37

MMA Enlists AMA to Help End Inequity in Capitated Programs

The Minnesota Medical Association has won the American Medical Association's help in fighting the geographic inequities in capitated payments for public programs such as Medicare and Medicaid.

Background

The MMA, at the 1994 AMA Interim Meeting, had introduced Resolution 113, asking the AMA to support and work aggressively for geographic equity in General Assistance Medical Care, Medicaid, and Medicare capitation rates. This resolution was referred to the AMA Board of Trustees, which directed the Council on Medical Service to develop a report and recommendations to present to the 1995 AMA House of Delegates. The Council presented Report 3, which included five specific recommendations.

The Problem

The problem is that capitated Medicare payments to HMOs are based on an average adjusted per-capita

cost (AAPCC) that varies widely from county to county and from state to state. Minnesota, a leader in managed care, is a loser under this payment arrangement. The AAPCC is supposed to reflect a cost of services that is comparable to fee-for-service costs, which in Minnesota are lower than in many other states. The inequities of the Medicare fee-for-service payment system are carried over to the capitated system. As a result, Minnesota HMOs receive lower capitated payments than HMOs in other states. In California, seniors in HMOs receive far more generous services, including prescription drugs, and they pay lower premiums than seniors in Minnesota.

AMA Response

The original recommendations in the Council on Medical Service's Report 3 failed to address the main issue, according to Thomas Stolee, M.D., past president of the MMA and an AMA delegate. Fortunately, testimony by Stolee and other supporters of the Minnesota resolution convinced Reference Committee A to make major improvements in the council's recommendations. The amended recommendations sailed through the House of Delegates with no opposition.

The first recommendation directs the AMA to continue to study methods to improve the adequacy, accuracy, and stability of capitated payments for Medicare and other public programs and to move away from county-level payment localities. The Minnesota amendment added the following key sentence: *Geographic variations in capitation rates for public programs such as Medicare and Medicaid should reflect only demonstrable variations in practice costs and use.*

"In my estimation, this was the major win for Minnesota at this AMA meeting," Stolee said. In testimony before Reference Committee A, he

explained why variations in use are important in a capitated system. "It doesn't take a Ph.D. to figure out that a patient in Northern Minnesota who lives 60 miles from the doctor is going to make fewer office visits than the patient in New York City who lives across the street."

The amended recommendations also call on the AMA to take the following actions:

- Work to assure that any current or proposed Medicare or Medicaid capitated payments, including waivers, be set at levels that *establish and maintain* access to quality care. The Minnesota delegation pushed for the addition of "establish" to this provision.

- Continue to develop products and services *to educate and provide technical assistance* to help physicians respond effectively to capitation or advise physicians where such products are available. The Minnesota delegation urged the committee to add the language in italics.

- Seek modifications, as appropriate, to the regulations or statutes affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations. There were no changes to this recommendation.

- The Council on Medical Service should continue to monitor and study all aspects of capitated payment *and associated compensation arrangements (e.g., fee-for-service, capitation, or salary)* and AMA activities to assist physicians and should report to the House of Delegates at the 1995 AMA Interim Meeting. The Minnesota delegation proposed the language in italics to address situations in which the third-party payer receives a capitated payment but may pay providers in a variety of ways, including fee-for-service, capitation, or salary.

These amended recommendations were adopted in lieu of Minnesota's Resolution 113 introduced at the Interim Meeting.

Coalition *continued from page*

Single payment districts would even out the tremendous disparities among states. For instance, if every state were one Medicare payment district, Minnesota would still receive \$13.23 for an office visit, coded 99211, adjusted by the 1996 GPCI. But New York's reimbursement would be \$15.59 throughout the state. This would be a loss for Manhattan, which currently receives \$17.29, but a gain for other parts of New York state. With single state districts, the highest reimbursement level in the nation for CPT code 99211 would be \$15.74 in Alaska.

The Geographic Coalition will continue to consider ways to even out unfair differences in reimbursement.

• • • • •

AMA Urges Total Transformation of Medicare

The American Medical Association has proposed a plan to restructure Medicare that the association says will save \$162 billion over a seven-year period. The AMA unveiled its proposals for transforming Medicare at the AMA Annual Meeting in Chicago and has presented them to Congress and the Clinton administration.

The most dramatic AMA proposal is the addition of a new Medicare option, "Medichoice." The government would give beneficiaries who choose this option a lump sum they could use to buy private coverage. The government's contribution would equal the cost of providing traditional Medicare coverage. The AMA proposal also calls for changes in cost sharing, an increase in the eligibility age to reduce the number of people in the Medicare program, modest means testing, and the elimination of price controls.

Choices to Promote Competition

Under the AMA proposals, a Medicare beneficiary would have several choices.

1) Stay in a revamped but traditional Medicare reimbursement system.

2) Join a Medichoice program based on the Federal Employees Health Benefit Plan. This option would allow people to buy a wide range of private coverage, including indemnity insurance and managed care plans. The government would contribute a fixed amount toward the cost of a Medichoice plan and would provide information about participating health plans in the area.

3) Choose a catastrophic plan coupled with a tax-exempt Medical Savings Account. The government's annual contribution would go into an MSA, and the beneficiary could use this money to pay for medical expenses, a high deductible catastrophic insurance policy, and/or long term care. Unspent balances

would accumulate in the fund.

Changes in Traditional Medicare

The traditional Medicare system would be changed in three ways.

1) There would be only one type of cost sharing—a yearly deductible amount. After the beneficiary reached the deductible, all costs would be paid by Medicare. Beneficiaries who did not use their deductible amount would get a refund.

2) There would be no need for Medigap insurance.

3) Price controls would be eliminated. Physicians would set and disclose their fees. Or they could set their own conversion factor and publicize it so people could shop and compare. Beneficiaries would pay any difference between the amount reimbursed by the Medicare program and the physician's standard fee.

Means Testing and Increase in Eligibility Age

The plan calls for some means testing. People whose income is at or below the poverty level would be exempt from paying the Medicare deductible. Those with incomes between the poverty level and 150 percent of that level would pay a reduced amount adjusted on a sliding scale based on income. High-income beneficiaries, individuals who earn more than \$50,000 and couples who earn more than \$100,000, would receive a smaller Medicare subsidy.

The number of people in the Medicare program would be reduced. The AMA plan would raise Medicare's eligibility age so that it is consistent with Social Security. Legislation passed by Congress in 1983 calls for a gradual increase in the age when people are eligible for Social Security. The current eligibility age of 65 will be gradually increased to 67 by the year 2005. The phase-in begins in 2003.

Medical Education Funding Changes

The AMA also proposes that Medicare reduce its support for graduate medical education (GME) and that the private sector play a greater role in work-force planning and funding of GME. The first step would be a gradual reduction in the number of PGY-1 residency positions funded through the Medicare direct and indirect medical education adjustment. There would be a gradual transition to a GME funding system supported by all payers, including government and private insurance and managed care companies.

Quality and Health Plan Standards

The AMA proposes a "Partnership for Health Care Value" organization to focus private efforts to promote quality and rules for fair competition.

Regulatory Relief

The AMA aims to correct the competitive disadvantage of physician-sponsored health plans through antitrust relief and professional liability reform.

MMA Response

The MMA is analyzing the AMA proposals and considering how this comprehensive plan will affect Minnesota physicians. Watch *The Monitor* for more information on this crucial issue. • • • • •

Peer Reviewers Needed

The MMA peer review program is seeking physicians willing to conduct peer review on an occasional basis. Specialists in cardiology, ob/gyn, neurosurgery, and ophthalmology are particularly needed. For information about the program and the consultant's role, please call Katherine Kennedy, MMA Peer Review program director at 612/378-1875 or 800/999-1875.

Governor Honors MMA Women Physicians

Doris Brooker, M.D., and Jean L. Harris, M.D., were among 22 Minnesota women recognized for their leadership at the Fifth Annual Governor's Women's Leadership Breakfast May 19 in St. Paul.



Doris C. Brooker, M.D.

Doris C. Brooker, M.D., a member of the academic and clinical staffs at the University of Minnesota in Laboratory Medicine, Pathology, and Obstetrics and Gynecology, is recognized nationally as an expert in the field of women's health. Winner of the Minnesota Woman Physician of the Year Award in 1990, Brooker has done extensive medical research and has written many papers on infectious disease and gynecological cancer. Brooker told *The Monitor* she has seen a dramatic improvement in the attention paid to women's health in the last 15 years. "Since 1985, at the federal and at our own state level, research into women's health issues such as breast cancer, pregnancy care, and hormone replacement have received more money from public and private sources. The pharmaceutical industry voluntarily began conducting studies on how drugs affect women and the elderly. There has been a tremendous improvement in efforts to answer the questions we all have about women's health."

A member of the MMA since 1982, Brooker chaired the MMA Women Physicians Committee for eight years. Currently a member of the Minnesota Board of Medical Practice, she has put formal involvement in MMA committees on hold to avoid conflicts of interest.

In the 1950s and 1960s, there were only a few women physicians in Minnesota; now there are 2,300, according to Brooker. She said that professional opportunities for women in medicine have improved as the number of women entering the profession has increased. "People used to think women couldn't make decisions or be surgeons or deans. Only in the last 15 years have I seen women succeed. It takes a long time for people to prove their worth and gain experience. I am very optimistic about the future."

Brooker told *The Monitor* that she appreciated the leadership award. "But there's an old Texas saying," she added. "If you see a turtle on a fence post, you know it didn't get there without some help. I've had a lot of help from both men and women during my career." She said there are many other women physicians who also deserve recognition.



Jean L. Harris, M.D.

Jean L. Harris, M.D., is senior associate director and director of medical affairs at the University of

Minnesota Hospital and Clinic and is the mayor of Eden Prairie. Active in both medicine and public service, Harris has worked in the fields of education, government, foundations, and corporate and private practice. Currently she supervises the outcomes management program and a continuous quality improvement program for patient care and administration at the University of Minnesota Hospital and Clinic. Her responsibilities cover a broad range of activities including credentialing, infection control, clinical pathways development, utilization review, and cost containment. "The latest buzzword is 'clinical effectiveness,'" Harris said. "Clinical effectiveness is determined by the efficiency and quality of operation. But if you don't measure, you don't know if you have been effective. We measure three things to determine clinical effectiveness—quality of care, outcomes, and cost. They all interface."

After eight years on the Eden Prairie City Council, Harris is serving her first term as mayor. "We use some of the same techniques of continuous quality improvement in city government as we do at the University Hospital," Harris said. "Eden Prairie has been very effective in cost containment. We have reduced insurance premiums, and we have the best record in the state in workers' compensation."

The first black woman to graduate from the Medical College of Virginia, Harris was honored with the Jean L. Harris Scholarship, which awards medical school scholarships to minority students. She was the first woman and the first African-American to be appointed to the governor of Virginia's cabinet. Harris serves on many nonprofit committees and boards, including the Girl Scout Council, the United Way, and Eden Prairie Center for the Arts. The governor's introduction summed it up: "In whatever she does, Jean Harris strives to improve the quality of the process by focusing on good management and outcomes assessment. In our assessment, she deserves recognition for many jobs well done."

• • • • •

.....

ANNOUNCEMENTS

JOIN AN MMA COMMITTEE

Serving on an MMA committee is an excellent way to keep up-to-date on interesting issues and to voice your concerns and opinions. The MMA Committee on Bylaws, Committees and Membership has begun the process leading to appointment of members of the MMA's standing committees for terms beginning January 1, 1996. The committees are: Accreditation and Continuing Medical Education; Administration and Finance; Bylaws, Committees and Membership; Communications; Ethics and Medical-Legal Affairs; Legislation; Medical Practice and Planning; Minority Affairs; Professional Liability; Public Health and Preventive Medicine; Women Physicians; and Workers' Compensation. To be considered for appointment to a committee, please call your component medical society or call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875. She can also give you more information about the activities of each committee and about the appointment process.

.....

BMP ADVISORY COUNCILS HAVE VACANCIES

Although applications were originally due in June, there are still vacancies for physicians on Board of Medical Practice Advisory Councils.

The Physical Therapy Council of the BMP has an opening for one physician. This seven-member council advises the BMP on all matters relating to physical therapy as well as on physical therapist registration and disciplinary matters. Members are appointed by the BMP. Compensation of \$55 per day plus expenses is provided.

The Respiratory Care Practitioners' Advisory Council has openings for two physicians with expertise in respiratory care. The council advises

the BMP on respiratory care practitioner standards, applications for registration, complaints and disciplinary actions, continuing education programs, and enforcement of respiratory care practitioner rules. The council meets monthly at the BMP for one to two hours. Members are appointed by the commissioner of health. The compensation is \$55 per day plus expenses.

Application forms may be obtained from the Office of the Secretary of State, Open Appointments, 180 State Office Building, 100 Constitution Avenue, St. Paul, MN 55155-1299, or in person at Room 174 of the State Office Building. The phone number is 612/297-5845.

.....

HTAC IS CHOOSING TECHNOLOGIES TO EVALUATE

The Health Technology Advisory Committee has narrowed down the list of technologies that it may evaluate in 1995. HTAC will choose from the following list: acupuncture for treatment of chronic pain, apnea monitors for SIDS/infants, chickenpox vaccine, chiropractic treatment for conditions other than low back pain, screening for high cholesterol, comprehensive lead screening for children, left and right ventricular assist devices, Lyme titer for diagnosis of Lyme disease, pulmonary shaving/laser-bullectomy/pneumectomy for emphysema, RU-486 for termination of pregnancy, and TMJ treatment for pain and/or range of motion limitations. If you have comments, send them to Mary Fahey, HTAC, 121 East Seventh Place, Suite 400, PO Box 64975, St. Paul, MN 55164-0975. Or you may call her at 612/282-6355.

Currently, HTAC is in the process of evaluating neuro-imaging for the diagnosis of headache and electronic fetal monitoring during labor. In

addition, HTAC recently began to evaluate autologous bone marrow transplants and pancreatic transplants for diabetic patients.

.....

CONGRESS PROPOSES DEEP BUDGET CUTS

The House and Senate have reached agreement on a budget proposal that would balance the federal budget in seven years by cutting spending by \$1.2 trillion. The bill would reduce the growth of Medicare spending by \$270 billion and would reduce the growth of Medicaid funding by \$182 billion over seven years. The actual changes in current law will be drafted in the House Ways and Means and Commerce Committees and included in reconciliation legislation.

The Monitor

AUGUST 1995

...

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

...

Physician Collective Bargaining

Antitrust Prospects and Pitfalls

Current options allowing competing physicians to collectively negotiate fees fall short of explicit immunity and leave physicians without complete protection.

Bradley G. Clary, J.D.

Naturally, physicians want more bargaining clout for negotiating fees with ever-larger third-party payers. Physicians may ask: Should indemnity insurers, managed care plans, and other health care financiers be able to force small, independent physicians to swallow reduced fees for services, while the antitrust laws prevent the physicians from banding together to even the playing field?

Physicians may find it heartening to know that there are, in fact, some ways in which they may act collectively, although collective negotiations must be carefully structured to avoid antitrust concerns. Existing legislation provides some leeway, and the American Medical Association (AMA) and the Minnesota Medical Association (MMA) are pursuing various legislative initiatives. This article briefly explores some of the prospects and pitfalls of physician collective bargaining.*

General Principles

A basic purpose of federal and state antitrust law is to reduce prices of goods and services in the marketplace. A fundamental premise is that competition, rather than collaboration, is generally more likely to produce better quality products and ser-

vices at lower prices. Thus, the antitrust laws prohibit agreements that unreasonably restrain trade and condemn agreements among direct competitors to fix the prices at which they will sell their products or services.

Agreements among competitors regarding pricing terms can give rise to potential criminal liability exposure. In *United States v. Alston*,¹ for example, a jury convicted three dentists of a conspiracy to raise the copayment fees they were receiving from dental plans. Although a U.S. Court of Appeals ultimately ordered new trials and the U.S. Justice Department later dropped the case after obtaining a fine, the criminal charge serves as a stark reminder of the serious risk associated with pricing agreements among competitors.

Integration

A conspiracy to fix prices obviously requires participation by more than one person or organization; one individual or entity is legally incapable of such conspiracy. In essence, this is why so much attention has been given to the concept of integrated service networks, one legal means for physicians to integrate economically.[†]

Under the basic concept of an integrated network, when physicians (or physicians and other persons) join together economically to offer a product or service, they can effectively become a single entity for that purpose. The economically integrated network should not be deemed a

per se illegal price-fixing conspiracy, although it may still be scrutinized as such. It may be scrutinized to see if it unduly concentrates power over a particular market, or to ensure that it is not simply a sham device to disguise unlawful activity. Moreover, the network may be carefully reviewed to make sure it does not impose restrictions that unreasonably restrain the activities of the network partners outside the legitimate scope of the venture.

The presence of certain features in an economically integrated network will likely eliminate or greatly reduce the risk of any claim that the network is simply a price-fixing conspiracy among competitors. The network should:

1. include mechanisms, such as capitation or substantial withholds, for the physicians collectively to share profits and losses;
2. include mechanisms for the physicians to pool substantial capital;
3. include mechanisms, such as utilization review, quality parameters, and joint administration, functionally and administratively to inte-

†One formal description of ISNs is embodied in the Minnesota Integrated Service Network Act, Chapter 62N of the Minnesota Statutes. A general description of ISNs is also found in the "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust," issued by the U.S. Department of Justice and the Federal Trade Commission on September 27, 1994.

*Because the issues are complex, this simplified overview is not intended as legal advice or as a substitute for detailed analysis of antitrust risks presented by specific circumstances.

grate the delivery of services;

4. use the above mechanisms to generate efficiencies in the delivery of medical services;

5. offer a variety of services (one-stop shopping) that the physicians could not offer individually.

State Statutory Assistance

Minnesota statutes provide a couple of laws designed to assist physicians in cooperating without running afoul of the antitrust laws. These allow for health care cooperatives, under Chapter 62R, and set forth the Minnesota-Care antitrust exceptions, found in Minn. Stat. § 62J.2911 et. seq.

Health care cooperatives statute

This statute enables physicians to combine into cooperatives to offer health care services. Section 62R.06 says that a provider cooperative will not be deemed a combination in restraint of trade, and "any contracts or agreements between a health care provider cooperative and its members regarding the price the cooperative will charge to purchasers of its services, or regarding the prices the members will charge to the cooperative ... are not contracts that unreasonably restrain trade."

Unfortunately, it is unclear whether the above language provides meaningful antitrust protection. For one thing, the comforting language in Minn. Stat. § 62R.06 is made subject to a later provision (62R.08) that describes certain prohibited practices and then states that these prohibitions are in addition to any conduct that violates the Minnesota Antitrust Law. Did the right hand take away what the left hand just gave? Moreover, it is not clear whether helpful language in the health care cooperatives statute is of any comfort with regard to federal antitrust law enforcement (even assuming it bars state antitrust law enforcement).

The MinnesotaCare antitrust exceptions process

Minn. Stat. § 62J.2911 enables parties in a collaborative health care arrangement to apply to the Minnesota commissioner of health for approval of that arrangement. Under the legislation, the health commis-

sioner's approval of a proposed arrangement provides an absolute defense to an action challenging the arrangement under state antitrust law. In addition, the statutory process is designed to enable parties in an approved arrangement to claim state action immunity from federal antitrust law.

In brief, the state action doctrine provides that the conduct of parties that is undertaken in accordance with a "clearly articulated and affirmatively expressed" state policy, "actively supervised" by the state, is immune from federal antitrust enforcement. In theory, therefore, if the Minnesota commissioner of health reviews and approves a proposed arrangement among physicians to collectively negotiate prices with health plans, under appropriate supervision, antitrust immunity should be obtainable.

The approval process, however, has some drawbacks. First, to date, only one application has gone through the full process (the merger between LifeSpan and Health One). In addition, this limited experience suggests the process is expensive and time consuming. Another potential problem is the unsettled definition of "active supervision." Some network arrangers may be fearful that state action immunity is a potentially hollow defense under the MinnesotaCare antitrust exceptions process, unless the participating physicians are prepared to accept substantial supervision by the Department of Health.

Proposed Legislative Initiatives

Physicians and their organizations, such as the AMA and MMA, have been trying to obtain antitrust immunity for collective bargaining with payers. Their proposals include such approaches as labor exemptions, safe harbors, certificates of review, and notification.

Labor exemption

The federal antitrust laws contain provisions exempting certain labor organization activities. Apparently, with this labor-exemption concept in mind, physicians in Florida have been

trying to sign up with the AFL-CIO-affiliated Federation of Doctors and Dentists, which represents state-employed doctors in Florida. Similarly, in January 1995, the MMA proposed legislation (H.F. 1812/S.F. 1637) that would have enabled small clinics (even without economic integration) to collectively bargain with "dominant health care benefits third-party payers." However, the bill did not receive a hearing during the 1995 Minnesota legislative session.

More and more physicians are becoming employees of payer organizations and related entities. For those physicians, some form of labor exemption for collective bargaining with their common employer is feasible. It is unclear, however, whether a labor exemption could be applied to collective fee negotiations by independent doctors with third-party payers. Application of the federal labor exemption assumes the existence of a labor group engaged in labor activities in the context of common employment.

In *American Medical Association v. United States*,² the AMA and the Medical Society of the District of Columbia were indicted and convicted of conspiring to prevent the Group Health Association from obtaining access to doctors. The defense argued that there was a labor dispute involving the terms of employment of GHA's doctors. The Supreme Court ruled that the AMA and the medical society were an association of individual practitioners, not an association of employees. Therefore, no labor exemption existed.

Moreover, state legislation designed to avoid similar results might only bar enforcement of state antitrust law, not federal. Accordingly, both state and federal legislative initiatives are needed.

Safe harbors

The Dole-Packwood Health Care Reform bill, which was introduced in the U.S. Senate in August 1994 (S. 2374) but never saw action, proposed turning the Department of Justice (DOJ) and Federal Trade Commission (FTC) "Statements of Enforcement Policy and Analytical Principles Relating to Health Care

and Antitrust" into antitrust safe harbors. The legislation proposed that conduct in compliance with the safe harbors would be defensible in all antitrust lawsuits, except for any claims for injunctive relief made by the federal agencies in "extraordinary circumstances." Federal legislation granting safe harbor status to collective negotiations with payers would, of course, immunize conduct from federal antitrust scrutiny. (Parallel state legislation would serve the same purpose at the state level.) The problem with leaving creation of the safe harbors in the hands of federal and state enforcement agencies, however, is that these agencies tend to view collective bargaining by competing physicians who are not economically integrated as an antitrust violation. Therefore, those agencies are not likely to propose any safe harbor that would immunize such conduct, and the Dole legislation

would not require such a safe harbor. Congress and the state legislatures will need to legislate their own safe harbors if physicians are to be truly protected.

Certificates of review

Another feature of the Dole-Packwood bill was a "certificate of review" concept. The idea was that health care providers could apply to the U.S. Department of Justice for a certificate that, if granted, would protect those providers against lawsuits for damages based on approved conduct (even though they could be sued for injunctive relief to stop the conduct). A "certificate of review" approach presents some interesting possibilities, but, again, it is unlikely that the DOJ would endorse collective fee negotiations by competing physicians who are not economically integrated. Therefore, certificates would likely be rejected

if requests were required to go to the DOJ for initial approval. An alternative approach might be to place the certificate process exclusively in the Health Department, with the DOJ merely having a right to comment.

Notification

Finally, the Dole-Packwood legislation suggested permitting health care providers to form joint ventures and to notify the DOJ of their activities. Notification would not convey antitrust immunity but would, under various terms, preclude application of *per se* illegality rules in subsequent antitrust litigation. The legislation's provisions, however, did not clearly protect all proposed collaborative fee negotiations, because the notification provision did not protect "conduct which constitutes *per se* price-fixing." And it seems doubtful that providers would find non-immunity

Blue Cross v. The Marshfield Clinic

An antitrust case that has attracted considerable attention recently is *Blue Cross and Blue Shield United of Wisconsin and Compcare Health Services Insurance Corporation v. The Marshfield Clinic and Security Health Plan of Wisconsin, Inc.* In that lawsuit, Blue Cross and its HMO sued Marshfield Clinic and its HMO, alleging that the defendants had committed various antitrust violations.

Oversimplified, the allegations fell into two general categories. First, Blue Cross alleged that Marshfield had monopoly power over the delivery of physician services in various parts of western Wisconsin and was misusing that power to prevent competing physicians and competing HMOs from entering the marketplace. Second, Blue Cross alleged that The Marshfield Clinic and the clinic's HMO subsidiary had agreed with certain competitors to allocate business. A Wisconsin federal court jury found for Blue Cross on both types of claims and entered a verdict of just over \$16 million, which was automatically trebled by statute to just over \$48 million. On post-trial motions, the presiding judge sustained the liability findings but reduced the damages award to about one-third of its original size.

This case provides two important lessons for physicians planning to form networks. First, a clinic with a dominant position in the delivery of physi-

cian services (for example, in a rural area where there are few other doctors) runs a serious antitrust risk if it refuses to deal on reasonable terms with health plans that need those services. (One of the allegations in the Marshfield case was that Marshfield simply refused to deal with the Blue Cross HMO on any reasonable terms.) Remaining questions, however, are whether such a clinic must offer the same terms to all competing plans, and whether such a clinic can be required to offer services on a capitated basis to any willing plan. A reasonable argument can be made that even a dominant clinic should not be required to deal with all potential payers on identical terms and, especially, should not be required to offer capitated services on identical terms. These important questions will likely be addressed by the U.S. Court of Appeals in Chicago when it hears the case on appeal.

A second important lesson is that a clinic cannot agree with independent competitors to allocate territories, services, or patients. Divisions of responsibility among clinics participating in an economically integrated venture to offer a new product or service, or to offer an existing product or service more efficiently, may be defensible within the venture. However, divisions of business among otherwise independent, competing clinics constitute *per se* illegal antitrust violations.

-BGC

satisfactory even if the notification rules were applicable.

Conclusion

If competing physicians want to engage in collective fee negotiations with third-party payers, they should, given current antitrust law and enforcement agency guidelines, be economically integrated. The only other method to gain reliable antitrust immunity is to pursue legislation at both the federal and state level that literally declares certain non-integrated collective bargaining immune from both federal and state antitrust law. Legislative solutions short of explicit immunity are likely to leave physicians without complete protection. MM

Bradley Clary is an attorney with Oppenheimer Wolff & Donnelly in St. Paul.

REFERENCES

1. 974 F2d 1206 (9th Cir. 1992).
2. 317 U.S. 519 (1943).

"Although we live in the country, work is just a short bike ride away... that's unique."



Donald R. Paugh, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a 55 year-old, multi-specialty group of 115+ physicians, has several practice opportunities throughout its practice locations. Currently, we are seeking:

WENATCHEE/EAST WENATCHEE

- Family Practice w/OB
- Ophthalmologist (w/retina)
- General Internist • Urgent Care
- MOSES LAKE/OMAK
- OB/GYN • Pediatrician
- Surgeon (General) • Orthoped
- Radiologist (General)

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807

FAX (509) 664-7178

CALL (509) 663-8711
ext. 5203



**Wenatchee
Valley
Clinic**

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell

Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.

Eight First Avenue South

Buffalo, MN 55313

Phone: 800-876-7171

or 800-295-6373

Fax: 682-4791

CONTINUING MEDICAL EDUCATION

ST. PAUL-RAMSEY MEDICAL CENTER

Mark your calendar now for these upcoming conferences:

FALL-SPRING CONFERENCE SCHEDULE

1995

- | | |
|----------------|--|
| October 5-6 | Infection Control in Long Term Care Facilities-Part I, St. Paul
(Part II is December 11-12) |
| October 21 | Justification of Aquatic Therapy: Functional Outcomes,
Clinical Research and Public Awareness, St. Paul |
| November 9-10 | Changing General Surgical Practices-1995, St. Paul |
| November 16-18 | Strategies in Primary Care Medicine, St. Paul |
| December 7-8 | Cardiopulmonary Medicine, St. Paul |

1996

- | | |
|----------------|--|
| February 22-23 | Burn Care Today, St. Paul |
| March 7-8 | Family Medicine Today, St. Paul |
| March 28-29 | Critical Care 1996, St. Paul |
| April 12 | ENT Update for Primary Care Physicians, St. Paul |
| April 18-19 | Ob/Gyn Update 1996, St. Paul |

INFORMATION AND REGISTRATION: Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992, Fax 612/292-4773

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

TURN TO THE SPECIALISTS FOR A DISABILITY INCOME DIAGNOSIS.

With all the changes taking place within the disability insurance (DI) industry, it's reassuring to know that there are still some things you can count on.

Take Paul Revere, for example.

Our commitment to non-
cancellable DI for physicians
remains as strong as ever.

Our prescription for physicians' DI insurance includes:

- 15% off each year's premium
- Guaranteed fixed rates for the life of the policy
- Fully portable coverage

How does your current plan compare? We'd be happy to provide a second opinion—at no cost and with no obligation. Contact our office today.

Minnesota Physicians Insurance Agency

3433 Broadway Street, NE
Suite 375
Minneapolis, MN 55413
Tel: (612) 623-2860
(800) 298-6627
Fax: (612) 623-2855

The Paul Revere Life
Insurance Company



Minnesota Physicians Insurance Agency rolls out new services to ensure your financial success!



MPIA's new time-saving services include:

- ★ Insightful estate planning, retirement planning and practice succession seminars.
- ★ Seminars to help your practice manager deal effectively with employee benefit issues.
- ★ Tax favored programs to help you keep and build more capital for your retirement.
- ★ New low-cost quality life

insurance and favorable underwriting on disability income protection to help you get more for less.

- ★ Employee benefit plans and insurance administration services for your practice that provide excellent coverage and will save your staff time.

For information or assistance with your insurance or financial needs please call MPIA at (800)298-6627.

Watch for upcoming seminar dates!

MPIA

MINNESOTA PHYSICIANS
INSURANCE AGENCY

*A physician-owned, for profit
corporation of the MMA and HMS.
A MMBR Company.*

ST. PETER

(continued from page 7)

While a fellow, she taught pharmacy undergraduates and Pharm.D. students. One student was her husband, the individual mainly responsible for her decision to switch to pharmacy. John is also a clinical pharmacist at HCMC and an assistant professor of pharmacy at the University of Minnesota.

"It's funny how things work out sometimes," she says. "John needed to complete four years of Army service. He became a practicing pharmacist at Ft. Hood, Texas, and I entered the Pharm.D. program at San Antonio. For two years we saw each other every other weekend. Then he got his Pharm.D. degree at San Antonio while I was doing my fellowship."

When a fellowship in pharmacokinetics and a clinical pharmacist position in nephrology both opened at HCMC in 1988, the St. Peters seized the opportunity. "I was looking for a job at the time, and John wanted to get some research experience—a fellowship," she says. "It just happened that the best positions were here, which was also close to our family. It was very convenient and lucky."

"When I got here, my role was evaluating the pharmacokinetics of drugs and monitoring drug therapy in hospitalized renal patients," says St. Peter. "Currently, I'm evaluating ways to expand our pharmacy services to our outpatient dialysis units."

The Veterans Affairs Medical Center has been especially progressive in allowing clinical pharmacists to act as primary caregivers in clinics serving patients with diabetes, lipid disorders, hypertension, and other conditions, says St. Peter. Now other hospitals, including HCMC, are joining in. St. Peter's husband, for example, assesses chronic stable patients on routine follow-up and recommends medications at the HCMC Endocrinology Clinic under clinic director Mehmood Kahn, M.D., who confirms his evaluations.

"Physicians now being educat-

ed—for example, the medical residents on our renal service—know what trained clinical pharmacists can do, what their knowledge base is, and how they can help them out," says Wendy St. Peter. "I think many of the physicians now being trained are very comfortable with our role. Some physicians probably feel uncomfortable. It's a matter of getting to know those physicians, working with them, and gaining their trust."

The expanding role of the pharmacist in patient care is also being felt in outpatient settings, even in the neighborhood drug stores. The University of Minnesota Pharmaceutical Care Project has developed a model for implementing comprehensive pharmaceutical care in the community practice setting (see related stories, pages 10 and 14). "Instead of just dispensing medications and preparing notes about how to use them, community pharmacists are learning to evaluate the patient in the outpatient setting," says St. Peter. "They are being trained to evaluate patients and know what to look for in terms of compliance, drug interactions and

duplications, and dosage, particularly in patients with chronic diseases like diabetes and hypertension."

Pharmaceutical care, both as a concept and a growing reality, is in many ways a natural evolution, given the high level of public trust and confidence pharmacists have always enjoyed. With the additional training provided through Pharm.D. education and post-Pharm.D. training, clinical pharmacists are well positioned for the transformation to managed care.

"This is an exciting time for pharmacy," says St. Peter. "The opportunity is there. We need to reach out and grab it. I think the physician acceptance is there. Not everywhere, but a lot of medical residents are being trained with pharmacists now and they ... understand what skills pharmacists actually have. They can appreciate what we bring to the health care system."

MM

William Hoffman is assistant to the director of the Biomedical Engineering Center at the University of Minnesota and a free-lance writer.

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.

Employee Benefits Attorneys
2600 Eagan Woods Drive, #450
Eagan, MN 55121-1152

Practice limited to ERISA since 1988
Tel: 612-452-9322
Fax: 612-452-9355

Look for this seal



The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBeR), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this Seal. This Seal is your assurance that the product or service offered meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the  the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR. physicians working for physician

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

People and Places Making Medical News

People

Minnesota Health Commissioner

Gov. Arne Carlson has appointed **Anne Barry** commissioner of health. She was named acting commissioner in February, after then-commissioner Mary Jo O'Brien resigned in January. Since then, Barry has supervised the state's response to the meningitis outbreak in Mankato, the Group A streptococcus outbreak in Rochester, and the passage of Minnesota-Care during the 1995 legislative session.

Barry joined the Department of Health in 1993 as deputy commissioner. She has a law degree from William Mitchell College of Law and a master's degree in public health administration from the University of Minnesota.

FPA Board

John T. Anderson, M.D., and **Barry A. Bershow, M.D.**, were recently elected to the board of directors of Fairview Physician Associates (FPA) by the organization's membership. Anderson is an orthopedic surgeon with Orthopedic Surgeons, Ltd., and currently serves as chief of staff at Fairview Southdale Hospital. He has served one year on the FPA board, and his new term runs three years. Bershow is a family practitioner affiliated with Burnsville Family Physicians, P.A. He also will serve a three-year term.

Foundation HealthSystem Minnesota Directors

The Foundation HealthSystem Minnesota has elected the following four new members to serve on its board of directors: **Mario Petrini, M.D.**, Bloomington, gynecologist at Methodist Hospital

HealthSystem Minnesota; **Renner Anderson, M.D.**, Minnetonka, pediatrician at Park Nicollet Clinic HealthSystem Minnesota; **Kathleen Newell, Ph.D.**, Roseville, associate professor and director of the Division of Dental Hygiene in the School of Dentistry at the University of Minnesota; and **Roberta Mann-Benson**, Wayzata, president of the Roberta Mann Foundation.

Directors re-elected for three-year terms were **John Berg, M. Elizabeth Craig, M.D.**, **Carol Fredrickson**, **Lewis Mithum**, and **David Schall**. Foundation officers include newly appointed chair **John Berg**; newly appointed vice chair **Peter Throdahl**; **Constance Bakken**, secretary; **David McGowan**, treasurer; **Michael Johnson**, president; and **Steven Martin**, assistant treasurer.

Red Cross Distinguished Volunteer Service Award

Harold "Hap" LeVander Jr., a Woodbury resident and an attorney with the Maun and Simon law firm, was named the 1995 winner of the Harriman Award for Distinguished Volunteer Service at the recent national convention of the American Red Cross. As a member of the St. Paul Red Cross Board of Directors from 1975 to 1992, and of the American Red Cross Board of Governors from 1988 to 1994, LeVander led pioneering work in bone marrow transplantation, organ procurement, and tissue banking. The award recognizes his creative approaches to complex issues, especially in the biomedical services, and his role in advancing numerous life-saving Red Cross initiatives.

Mayo Benefactor

Long-time Mayo benefactor **Ruth Charlton Mitchell Masson** left part of her estate to the Mayo Foundation when she died in February at age 104, making her lifetime contribution to Mayo the second largest ever, a Mayo spokesperson announced in late June. The foundation and Masson's family would not specify the value of her contributions, but her lifetime gifts are expected to exceed \$30 million when her estate is settled. She had been a Mayo patient since the 1920s and started giving to the clinic in 1962.

Masson was originally from New England, but in the 1960s she moved to Rochester, where she later married her former surgeon, **James Masson, M.D.**, a past chief of Mayo's surgical staff who died in 1975. She is the daughter of **Earle Perry Charlton**, a founder of the F.W. Woolworth Co. She had no children.

Before her death, Masson donated Mayo's remodeled student center and a scholarship in memory of her first husband, **Frederick Mitchell**, who died in 1960. She also donated Mayo's first named professorship in memory of **James Masson**. Her willed gifts to Mayo include the house where she and Masson lived (a large Tudor house near the clinic), as well as the proceeds from the sale of a stamp collection and the original will of **Lord Horatio Nelson**, the British naval hero.

Places

University Wins Approval for Experimental Gene Therapy

The University of Minnesota received approval from the Food and Drug Administration to begin an experimental gene therapy to

Rx: Home Care

Our Comprehensive Services have been expanded to include an In-House Pharmacy.

With our new pharmacy we can help you:

- create an appropriate drug therapy plan of care
- select infusion devices and supplies
- resolve safety issues regarding home drug administration
- monitor adverse drug and device events
- prepare intravenous drugs for infusion

Questions regarding choice or use of intravenous drugs or therapies in the home? Call our Home Care Pharmacists at 628-1878.



HealthSpan
Home Care & Hospice

Governor Approves Relocation of HealthEast Bethesda

Gov. Arne Carlson signed a bill this legislative session that included a proposal to move the HealthEast Bethesda Lutheran Care Center, a long-term care center in St. Paul, from its current location to HealthEast Divine Redeemer Hospital in South St. Paul, closed since March 1994. The planned move had been on hold since last year, when the proposal was vetoed as part of the controversial Health and Human Services Omnibus Bill.

Construction to modify HealthEast Divine Redeemer may begin this fall, with possible completion by next spring. Renovating the HealthEast Divine Redeemer building will cost around \$2.3 million—\$6 million less than the estimated cost to renovate the HealthEast Bethesda Lutheran Care Center facility.

The HealthEast Bethesda Lutheran Care Center is two blocks from the state Capitol, across the street from HealthEast Bethesda Lutheran Hospital and Rehabilitation Center. In 1994, the governor's office and HealthEast were in negotiations about the purchase by the state of the entire HealthEast Bethesda campus, which also includes a vacant nursing school dormitory located up the street from the Capitol. The two sides could not come to an agreement, and in December the governor withdrew \$1.5 million set aside in his budget to do a feasibility study.

Socioeconomics

United HealthCare Acquiring MetraHealth

United HealthCare Corp. plans to purchase MetraHealth Companies Inc. of McLean, Virginia, for an estimated \$1.65 billion, making it the nation's largest health care management services firm. If the purchase passes regulatory and shareholder approvals, it will

treat Hunter syndrome. Only six universities in the nation have received approval to manufacture the tamed-virus vectors for gene therapy clinical trials, and the University of Minnesota is the first to receive approval to test the experimental treatment on adults with Hunter syndrome.

Minnesota Hospital Groups Merging

The Metropolitan Healthcare Council (MHC) and the Minnesota Hospital Association (MHA) are planning to merge the associations into a new organization. A Joint Leadership Committee that includes board members of both organizations has been meeting over the last few months to direct the development of a plan for merging. The committee retained KPMG-Peat Marwick to make

recommendations. In late June, the two associations' boards of directors met to discuss KPMG's recommendations and passed resolutions approving them. The plan calls for the new organization to be operational on or before October 1, 1995. An executive search firm was hired to conduct the search for a chief executive officer.

"Minnesota is a diverse health care state, with large health networks, health care provider cooperatives, and small, independent hospitals," said Stephen Rogness, president of MHA. "The new organization will encompass that diversity and truly represent Minnesota hospitals and health delivery systems."

MHA is a trade association that represents Minnesota's hospitals and health systems. MHC is a trade association that represents hospitals and health systems in the Minneapolis/St. Paul metro area.

create a company with more than \$8 billion in annual revenues and more than 40 million enrollees in a variety of programs.

Under the purchase agreement, United will pay MetraHealth \$1.15 billion in cash and \$500 million in convertible preferred stock. United sold its pharmaceutical benefit management business last year to Smith-Kline Beecham for \$2.4 billion in cash, so even after this purchase, it will have no long-term debt.

Minnetonka-based United HealthCare has more than 3.7 million members of owned or managed health plans and more than 27 million persons covered by various specialty services. MetraHealth, formed by last year's merger of the medical insurance companies Metropolitan Life Insurance Co. and Travelers, has about 11 million members nationwide, including about 114,000 in Minnesota.

Abbott Dismissing Nurse Anesthetists

Abbott Northwestern Hospital will no longer employ nurse anesthetists starting in two years; in the meantime, the hospital is offering financial incentives for the nurses to join Northwest Anesthesia, which will become the hospital's only provider of anesthesia services. Hospital administrators announced the decision in early July after a task force of nurses, physicians, and administrators failed to agree on an arrangement that would satisfy all the parties involved.

Last year, Mercy and Unity hospitals dismissed their nurse anesthetists, who were offered positions at a separate company controlled by anesthesiologists. Mercy, Unity, and Abbott Northwestern are all Allina Health System hospitals.

The dismissal was announced one day after the Minnesota Court of Appeals ended a restraining order imposed on Allina Health System and a St. Cloud hospital by a lower court when the Minnesota

Association of Nurse Anesthetists filed an antitrust suit against the hospitals. The order prohibited Allina from taking any adverse action against its nurse anesthetists. The antitrust suit and a related suit are still pending.

Blue Cross Expanding Networks

Blue Cross and Blue Shield of Minnesota and HealthSystem Minnesota have forged a partnership agreement whereby HSM's Park Nicollet and 11 other clinics will become part of the provider

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

612-885-6224

1-800-842-6469



network for Blue Cross's new Preferred Seniors health plan. The agreement more than doubles the health plan's number of clinics. Blue Cross hopes to increase plan enrollment from its current 200 members to 5,000 by the end of 1996.

Blue Cross also is expanding its presence in central Minnesota with the addition of the 30-physician St. Cloud Medical Group to Affiliated Community Health Network, a joint venture between Blue Cross and Affiliated Community Medical Centers of Willmar. The addition brings the network's New Pioneer Health Plan CISN to the St. Cloud area.

Under the new agreement, the groups plan to increase health care access in St. Cloud by establishing an urgent care facility—the first of its kind in the market—and hiring new physicians to offer convenient after-hours access to non-emergency health care services. The joint venture also plans to provide mobile health care services to employers for pre-employment screening, blood testing, and other health care services at the job site.

Blue Cross Starting Package Pricing for Cardiac Care

Blue Cross and Blue Shield of Minnesota and certain providers in its cardiac network have agreed to use "package pricing" for cardiac care in an attempt to hold down costs.

The provider groups, Fairview Riverside Medical Center, Fairview Southdale Hospital, Abbott Northwestern Hospital and the closely affiliated Minneapolis Heart Institute, have agreed to a plan whereby they receive a fixed rate for certain cardiac services. The plan packages together fees from the hospital, cardiologists, radiologists, and anesthesiologists. The physicians and hospitals will have financial incentives to find more cost-effective ways to deliver high-quality services because they

will share in any savings they realize.

A pilot program to test the impact of package pricing was conducted by Medicare beginning in 1991 for coronary bypass surgery. The Medicare study found that in addition to significant cost savings, package pricing resulted in shorter hospital stays, improved hospital-physician communication, and increased patient satisfaction, without any decrease in quality.

Hayward Medical Group Merging With Duluth Clinic

The Hayward Medical Group in Hayward, Wisconsin, merged with the Duluth Clinic effective July 12. Under the merger agreement, the groups will recruit additional primary care physicians and develop a new building for the Hayward Medical Group.

Duluth Clinic, established in 1915, is a regional health care system with more than 260 physicians representing 42 specialties and subspecialties in 22 cities throughout northeast Minnesota, northwest Wisconsin, and the Upper Peninsula of Michigan. Hayward Medical Group was established in October 1969 and has about 20 employees, including two family physicians, as well as two internal medicine physicians joining its staff this summer.

Law & Policy

Blue Cross Settles Coinsurance Dispute

Blue Cross and Blue Shield of Minnesota has settled a lawsuit over the way in which subscribers' coinsurance payments have been calculated. The agreement, which was reached through mediation and is subject to court approval, calls for BCBSM to pay \$3.9 million plus \$600,000 in plaintiff attorney fees as settlement in the class action suit. Most of the amount will go directly to subscribers, with a small amount being

donated to a yet-to-be-named health-related charity.

The lawsuit claimed that the coinsurance payments (the portion of a medical bill paid directly by the subscriber) paid by BCBSM enrollees should have been based on the discounted fees negotiated with some hospitals, clinics, and physicians, rather than the retail cost of health services. "The issue is whether the savings from negotiated prices with health providers should be shared broadly with BCBSM subscribers through reduced rates or returned to individual subscribers on a case-by-case basis," said Richard Niemiec, BCBSM senior vice president of corporate affairs.

About 40,000 BCBSM subscribers are expected to receive refunds. Individual payments will range from less than \$25 to several hundred dollars. BCBSM will make the payments using its claims systems data, and individuals eligible for these payments will not need to file special claims.

Caremark Paying \$161 Million in Fraud Settlement

Caremark International Inc. is paying almost \$161 million to settle federal fraud charges, including \$9 million in criminal penalties for its Minnesota operations, according to the U.S. Justice Department. The settlement is one of the largest ever for federal health care fraud investigation, said U.S. Attorney General Janet Reno.

"Caremark acknowledges the improper conduct by certain employees, apologizes, and takes full responsibility for the wrongdoing," said Lance Piccolo, Caremark's chair and chief executive officer, in a prepared statement. The settlement "puts an end to a difficult and painful episode for the company."

The settlement includes \$29 million in criminal fines; \$81.75

million in restitution, damages, and penalties for the harm it caused government medical insurance programs; \$3.5 million in civil penalties for not keeping accurate records at its pharmacies; and \$2 million to the Public Health Service to fund treatment of AIDS in young people.

The company also has agreed in principle to pay about \$45 million to states for overbilling their Medicaid programs. Minnesota Attorney General Hubert Humphrey III said he expects that Caremark will pay more than \$2 million to Minnesota's Medicaid program.

Medical Research

'U' Researcher Says Treat Lyme Disease as Soon as Possible

A University of Minnesota researcher advises physicians to treat Lyme disease with antibiotics immediately after the related rash appears, before a blood test confirms the diagnosis. Early treatment can prevent the infection from spreading to the joints, heart, or central nervous system, said university researcher Jesse Goodman, M.D., an associate professor of medicine specializing in infectious diseases. He is principal investigator of a study published in the July 6 *American Journal of Medicine*.

Researchers in the study tested 76 blood samples from patients with typical skin rashes (erythema migrans) suspected of having early-stage Lyme disease to see how quickly the bacterium spreads. Goodman said he was surprised that polymerase chain reaction testing found bacteria in 14 of the samples, showing early spread. Bacteria was found in 10 percent of the patients who had no other symptoms than a single skin lesion.

"This study shows that invasion of the bacteria into the bloodstream does occur early, even in some people who are feeling completely well," he said in a Minneapolis-based *Star Tribune* article.

One Glass of Milk OK for the Lactose Intolerant

Most people who are lactose intolerant can drink up to 8 ounces of milk per day without developing severe symptoms, such as bloating, diarrhea, or gas problems, accord-

ing to a Minneapolis Veterans Affairs Medical Center study. The results are important because milk is a good source of calcium, said Michael Levitt, M.D., chief of research at VAMC.

VAMC researchers recruited 30

HealthEast Capitol Medical Laboratory offers solutions

Providing services to physician office laboratories, long term care facilities, home care agencies, group homes, and corporate health and wellness programs • Professionally staffed • Locally owned and operated • Open 24 hours, 7 days/week • Member HealthEast Community Based Services

Providing solutions and expanded services for your office. For more information, contact CML Marketing at (612)

232-3246

HealthEast Capitol

Medical Laboratory

69 West Exchange Street

St. Paul, MN 55102

Customer Service: (612) 232-3500

• Minnesotans serving Minnesotans •

people of both sexes and various ages and races who believed they were severely lactose intolerant and who said they developed severe symptoms from small amounts of milk. The volunteers drank 8 ounces of regular milk with breakfast for one week, and 8 ounces of milk in which the lactose was predigested for one week. They did not know which they were drinking and recorded their intestinal symptoms. The study found that their symptoms were the same for each type of milk, showing that the lactose produced no or minimal problems.

Nine of the 30 people actually were not lactose intolerant. Levitt said most people who truly are lactose intolerant can comfortably drink a cup of milk daily because the colon can withstand a limited amount of milk sugar without producing symptoms. MM

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Urgent Care
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

M MULTICARE • ASSOCIATES
OF • THE • TWIN • CITIES

What's one of the biggest threats to your life's savings?

LONG TERM CARE.

Long term care is the major catastrophic health care expense faced by older Americans.

Financially, long term care can and does impoverish thousands of people each year.

WHY?

Because Medicare and Medigap insurance only cover short-term medical and rehabilitative services. You still need private insurance for long term care...especially if you want to choose where you'll receive that care – at home or in a nursing home.

That's what The Travelers Independent Care insurance is all about—protecting your life's savings and your independence. *What's more, it's one of the most affordable long term care policies available, with extensive home health care benefits.*

To find out more, call your Travelers agent today.

For more information contact:

MINNESOTA PHYSICIANS INSURANCE AGENCY

623-2860 Toll Free 800/999-1875

A network of counselors uniquely dedicated to serving the health care market.

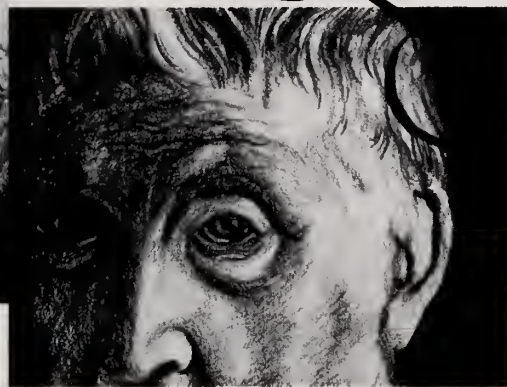
Representing

TheTravelers
Insurance Companies

©1994 The Travelers Insurance Company and its Affiliates
Hartford, Connecticut 06183



A COMMITMENT TO
Quality



STARTS WITH

Quality Peer Review

The Minnesota Medical Association is proud to announce its Peer Review Consultation Services. This program, tailored to meet state and federal guidelines, is designed for use by hospitals, clinics and other organizations that need peer review by an impartial third party.

Reviewing physicians

- ♦ are either board certified or eligible in appropriate specialties or subspecialties
- ♦ have been trained in objective peer review procedures
- ♦ will conduct reviews on-site or off
- ♦ will provide an advisory report containing background information, findings of fact and conclusions

To obtain confidential peer review consultation services, call the MMA and ask for Peer Review Consultation Services. In the Twin Cities call 378-1875. Outside the metro area call toll free, 1-800-999-1875.

The MMA is committed to helping you maintain and improve the quality of health care.

Call us today.



MMA

Minnesota Medical Association

An auto lease/purchase company solely dedicated to serving physicians.

MMBR Motor Services



Here's what MMBR Motor Services is committed to doing for you:

When you call us, we go to work providing free consultation to help you outline your vehicle needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle. Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease we will arrange to have your vehicle professionally detailed, assuring high resale value by helping keep your vehicle in top condition.

We provide complete support after the lease/purchase. If you have a question, call us.

For *personal attention* on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

A physician-owned, for profit
corporation of the MMA and HMS



would like to learn more about what
MMBR Motor Services can do for me
on the lease/purchase of my next vehicle.

Name _____

Address _____

City _____ State _____ Zip _____

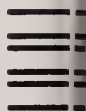
Please contact me at my ☐ Home ☐ Office

Phone number _____

I plan to ☐ lease ☐ purchase a new vehicle

Within ☐ 3 months ☐ 6 months ☐ 12 months

MN/MED



BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

NECESSARY IF
MAILED IN THE
UNITED STATES

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

AUGUST 1995

Aug. 18-19 **Advanced Life Support in Obstetrics** Hennepin County Medical Center/Hennepin Faculty Associates; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Ann Samways or Robin Hoppenrath, Hennepin County Medical Center Office of Academic Affairs, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415; 612/347-2075.

Aug. 27-30 **Minneapolis Transplant Congress: New Immunosuppressive Drugs** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

SEPTEMBER 1995

Sept. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Mental Health Issues for Primary Care Physicians** Allina Health System; Hotel Sofitel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12 **Molecular Biology for Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 14-17 **Mechanical Ventilation: Principles and Applications** University of Minnesota Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 16 **Endorectal Ultrasonography** University of Minnesota Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 22-23 **Nursing Home Medical Directors** University of Minnesota Continuing Medical Education; Sheraton Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 28-29 **1995 Duluth Oncology Conference** Duluth Clinic; Fitger's Theatre of the North, Fitger's Complex, Duluth, MN. CONTACT: Rockie Odberg, Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Sept. 28-30 **Animal Models of Cardiac Dysfunction** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 29-30 **Recent Developments in Epilepsy and Neurology** Allina Health System and Minnesota Epilepsy Group; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

You'll know your career is on the rise when

...You customize your practice to your interests...You receive productivity based compensation with excellent 1st year income guarantee...Consolidated organization of our 50+ physician multispecialty practice frees you from both office management and buy-in costs...Our comprehensive benefits give you at least 5 weeks vacation/CME time, malpractice, health, life, disability and dental insurances, and \$3750 CME allowance...You join The Monroe Clinic—a consolidated outpatient and inpatient healthcare facility combining a new 114,000 sq.ft. clinic and adjoining 140-bed acute care hospital with 24 hr. ER coverage serving south central WI and northern IL. We have openings for BC/BE physicians in:

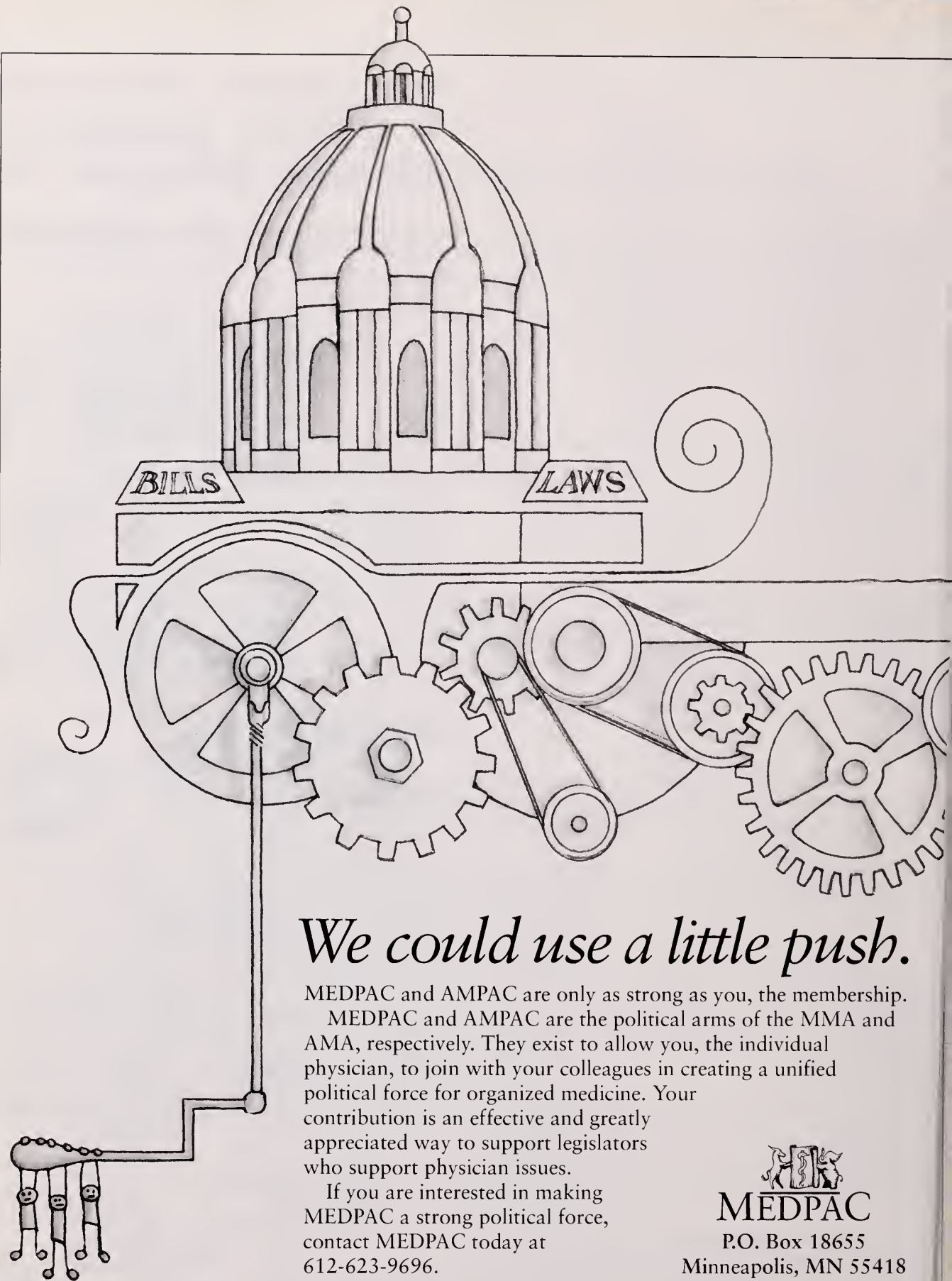
- Family Practice
- Outpatient Psychiatry
- Orthopedic Surgery
- Dermatology
- Emergency Medicine

You'll like the friendly neighbors and neighborhoods in four-season Monroe, Wisconsin, a family-centered rural community of 10,000 located just one hour from Madison, WI, Dubuque, IA, and Rockford, IL...and two hours from Chicago and Milwaukee. We enjoy excellent schools, a thriving economy, solid values, an abundance of parks and recreation centers, popular entertainment and shopping facilities, and easy access to nearby universities.

For more information write or call: **Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. 800-373-2564. Or fax resume to: 608/328-8269. EOE.**



The Monroe Clinic
A proud caring tradition



We could use a little push.

MEDPAC and AMPAC are only as strong as you, the membership.

MEDPAC and AMPAC are the political arms of the MMA and AMA, respectively. They exist to allow you, the individual physician, to join with your colleagues in creating a unified political force for organized medicine. Your contribution is an effective and greatly appreciated way to support legislators who support physician issues.

If you are interested in making MEDPAC a strong political force, contact MEDPAC today at 612-623-9696.



MEDPAC

P.O. Box 18655
Minneapolis, MN 55418

MEDPAC is a bipartisan organization endorsed by the Minnesota Medical Association and affiliated with AMPAC, an organization established by the American Medical Association. MEDPAC and AMPAC contributions should be written on personal checks. Funds from corporations or incorporated practices cannot be accepted for MEDPAC's political contribution fund; corporate checks will be accepted for non-election activities. Contributions are not limited to the suggested amount. Neither MMA nor AMA will favor or disadvantage anyone based on the amounts or failure to make PAC contributions. Voluntary political contributions are subject to prohibitions and limitations of FEC regulations (federal regulations require this notice). Contributions to MEDPAC or AMPAC are not deductible as charitable contributions for federal income tax purposes.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., August 15 for October ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Internal Medicine and Dermatology practice opportunities available at the Faribault Clinic. The Faribault Clinic is a multispecialty group practice of 18 physicians. Faribault is located 50 miles south of Minneapolis on I-35. For more information contact Ray W. Wood, M.D., or Ken Smith, Administrator, 924 NE First Street, Faribault, MN 55021; 507/334-3921. (4/94-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Mankato, Minnesota: FP needed to join group of four board-certified family physicians aged 37 to 47 in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

EXCEPTIONAL OPPORTUNITY

at BlueCross BlueShield of Nebraska:

We have an opening for a Chief Medical Officer, preferably with an internal medicine or family practice background, to help develop and shape our corporate medical policies. Interested candidates should see themselves as leaders, capable of interacting with our medical community as well as business leaders. We're looking for a physician with vision, business savvy, extensive knowledge of current medical issues, and a lot of energy. Candidates must be licensed to practice medicine in the state of Nebraska (or be able to meet the requirements to obtain a license in Nebraska). Managed Care Certification and/or experience is highly desirable. Contact Micki Baldino, Sr. Vice President, Human Resources, in Omaha, Nebraska, 402-390-1813.

We are an equal opportunity employer M/F.



Olmsted Medical Group is seeking BC/BE physicians in the following specialties: emergency medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates eight branch offices in southeastern Minnesota. Excellent salary/benefits package includes malpractice insurance, flexible benefits plan, 401(k) and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (1/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441. (*7/95-R)

Attention Physicians and Surgeons: We have locum tenens and permanent positions available nationwide. Please contact: Physician Search Consultants, 101 27th Avenue SE, Minneapolis, MN 55414; 612/627-9350. 2-8/95



**COASTAL
PHYSICIAN SERVICES
OF THE MIDWEST, INC.**

Your Private Practice Alternative in the State of Minnesota



- No on-call
- Medical Directorships
- Assured Income
- Group Practice

Brian Nunning
800-326-2782 • FAX: 314-291-5152

3221 McKelvey, Suite 106, St. Louis, MO 63044



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. *3-9/95

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE, to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Josephe E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-8/95

Primary Care Physicians for week-night, weekend, and holiday coverage at medical center in Rochester. Current BCLS and ACLS required; licensure from any state acceptable. Residents encouraged to apply. We offer flexible schedules and malpractice coverage. Contact in confidence Annashae Corp., Professional Healthcare Staffing, 800/245-2662. 1-8/95

Family Practitioner • Internist

BOTH **Want the best of worlds?**

Live and work in a rural community—yet have easy access to the educational, cultural, shopping, and entertainment opportunities of the big city. Enjoy all the benefits that go with small-town living—good neighbors, safe schools, affordable housing, abundant recreational choices—and go to the city when you want!

St. Croix Falls, Wisconsin is located just over the scenic St. Croix River from Taylors Falls, Minnesota and within 45 minutes of the metropolitan Twin Cities. With 25,000 households within the clinic service area, River Valley Medical Center is the region's largest and most diversified practice group—13 family practitioners, 2 internists, 2 general surgeons, 2 orthopedic surgeons and a physician assistant. Clinic is attached to a 50-bed acute care hospital with a wide range of services.

Guaranteed first-year salary with second-year partnership and excellent fringes.



Send detailed CV to:
Cathy Kortas
River Valley Medical Center
208 S. Adams St.
St. Croix Falls, WI 54024

Moonlight Home Care, Inc.



1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)

*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured**; we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare System

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine	OB/GYN
Internal Medicine	Neurology
Orthopedic Surgery	Pediatrics
Noninvasive Cardiology	Urology

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-4592.

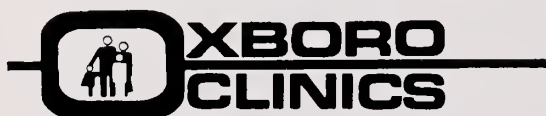
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient, Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

Family Physician to join the medical staff of five family practitioners in a well-established, growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Work in two newly constructed, modern clinics; one is attached to the hospital. Excellent subspecialty support, progressive community hospital, diverse patient population. Guaranteed salary with incentive plan and a broad range of benefits. Call collect, 612/532-3154, or write to Frederick W. Haack, Administrator/CEO, Mille Lacs Health System, PO Box A, Onamia, MN 56359.

*6-9/95

Urologist to join practice in pleasant Midwestern city. Modern hospital nearby. Very little managed care. Prefer oncology background. Please send résumé to Watertown Urology, 600 Fourth Street NE, Watertown, SD 57201; Fax: 605/886-9204.

2-8/95

Not Just Another Recruitment Ad: Opportunities at North Memorial-owned and -affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs, and ob/gyns thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs call 800/275-4790, or fax CV to 612/520-1564.

1-8/95

Physician (Internist)

The St. Cloud, Minnesota, VA Medical Center is a dynamic 556-bed facility providing excellent psychiatric and intermediate care to veterans.

An exceptional opportunity exists for a physician board eligible or board certified in Internal Medicine with an interest in doing primary care and general internal medicine consultations. We offer competitive salary and benefits combined with a stable 40-hour weekly schedule.

To explore this unique opportunity, call or write:

Thomas Plombon, Human Resources Management Service 612-255-6301 or
Dr. Susan Markstrom, Chief, Medical Service
612-255-6371
VA Medical Center
4801 N. 8th Street
St. Cloud, MN 56303

AIM HIGH

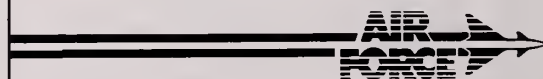
CREATE A MEDICAL BREAKTHROUGH.

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle, quality practice
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Call

**USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF**



Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



Central Minnesota
Group Health Plan

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C. F.
anderson
COMPANY, INC.

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Weekday hours only. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Jonathan Cohen, M.D., MPH
Director, Urgent Care/Emergency Department (1110),
Veterans Affairs Medical Center,
One Veterans Drive
Minneapolis, MN 55417
612-725-2000 ext. 2679



An equal
opportunity
employer.

St. Paul, Minnesota: BC/BE family physician to join a small suburban branch office of Ramsey Clinic—a 215-physician multispecialty group with affiliations with HealthPartners and St. Paul-Ramsey Medical Center—a regional tertiary care facility. The Maplewood office is a six-physician primary care clinic located in Maplewood, Minnesota, just 10 minutes from downtown St. Paul. At Ramsey Clinic-Maplewood, you can enjoy the practice style of a smaller practice, yet benefit from the professional and administrative support of our large multispecialty group. Opportunities to practice obstetrics or engage in teaching and research are optional. Send CV or contact: Karen Steiner, M.D., or Nancy Swenson, Manager, c/o Ramsey Clinic-Maplewood, 1774 Cope Avenue, Maplewood, MN 55109; 612/770-1497. 4-8/95

Part-time Medical Director: We currently have two openings within our medical department at Minnesota Mutual, a large national insurance company in the life and disability field, ranking in the top 1 percent of all insurance companies. Requirements for these positions include board certification (internal medicine/family practice preferred), Minnesota license, and four-plus years of experience preferred. This position allows you to use your medical knowledge to advise the company in mortality and disability analysis, as well as medical claims evaluation. We offer the opportunity for you to use your expertise in a stable and challenging work environment. Also included is a competitive salary

and flexible hours. Interested candidates are asked to send résumé or contact Steve Froeschl, Senior Employment Representative, Minnesota Mutual, 400 North Robert Street, St. Paul, MN 55101; 612/228-4982. 1-8/95

AUGUST 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	60
Aspen Medical Group	32
Blue Cross and Blue Shield of Minnesota	60
Central Minnesota Group Health Plan	63
C.F. Anderson Co., Inc.	63
Chisago Health Services	63
Coastal Physicians	60
Emergency Practice Associates	4
Fairview Clinic Services	51
HealthEast	Cover 4
HealthEast Capitol Medical Laboratory	53
HealthPartners	4, 23
HealthPartners Ramsey Clinic	4
HealthSpan Home Care & Hospice	50
MEDPAC	58
Minnesota Medical Business Resources	3, 48, 56
Minnesota Physicians Insurance Agency	45, 46, 54
MMA Peer Review Consultation Services	55
Moonlight Home Health Care	61
Multicare Associates of the Twin Cities	54
Norwest Center	32
Oxboro Clinics	62
River Valley Medical Center	61
Sletto & Associates, P.A.	47
St. Francis, Inc.	61
St. Paul-Ramsey CME	4
Thunderbird Aviation, Inc.	20
U.S. Air Force Health Professionals	62
Veterans Affairs Medical Center—Minneapolis	64
Veterans Affairs Medical Center—St. Cloud	62
Webb Financial Group	Cover 2
Wenatchee Valley Clinic	44
Whitesell Medical Locums, Ltd.	44

Thank you!



Thank you for your MMA membership.

Your membership contributed to a successful 1995 legislative session. This year you helped achieve a number of victories for Minnesota physicians. Your involvement has won passage of the MinnesotaCare bill; major provisions include:

- Repeal of the regulated all payer option (RAPO)
- Inclusion of the MMA's data collection and utilization review provisions
- Repeal of the state's practice parameters committee
- Prohibition of the transfer of MinnesotaCare funds into the general fund
- Creation of a direct contracting pilot program for providers and purchasers.

You also reduced the felony penalty for criminal neglect in the Vulnerable Adults Act and kept the definition of criminal neglect and the penalty the same as in current law.

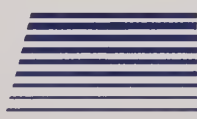
You passed the prompt pay bill requiring the Department of Human Services to pay provider bills on time or add an interest payment.

You passed a provision moving GAMC and Medicaid capitation rates toward geographic equity.

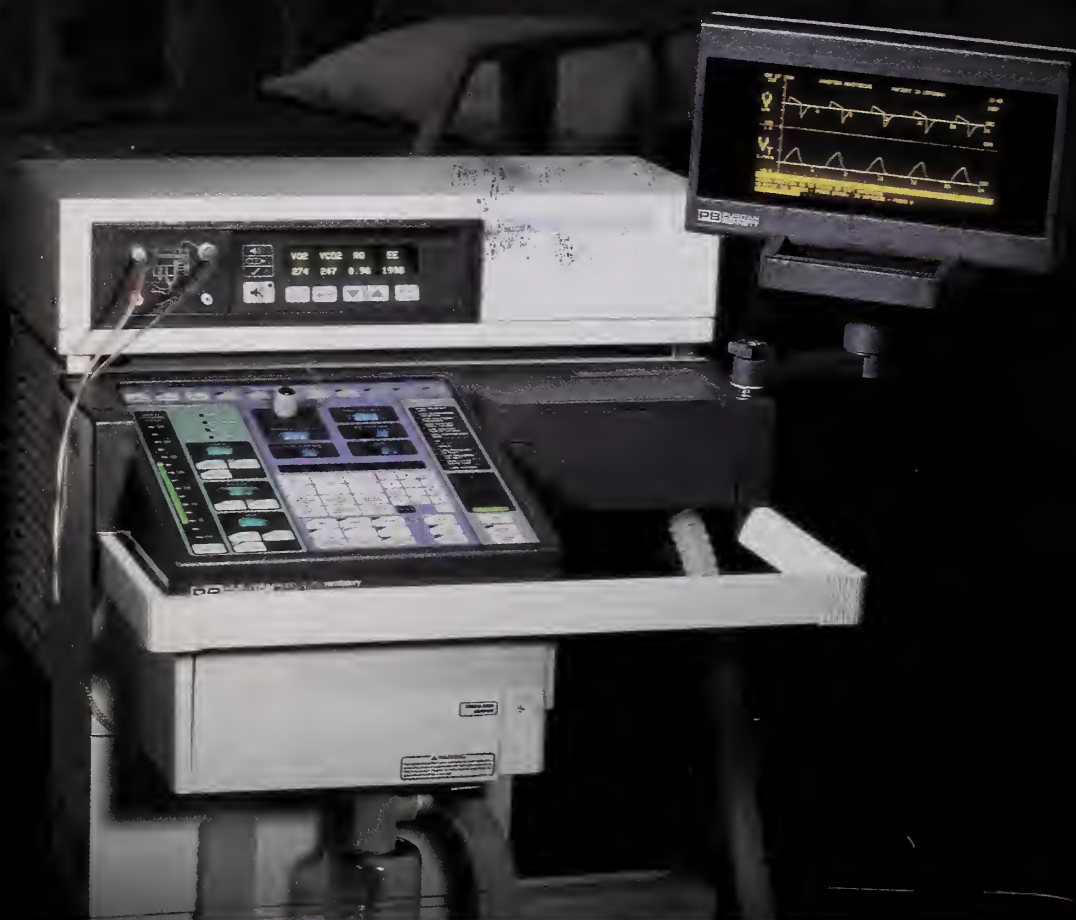
You defeated a provision that would have allowed managed care plans to discount provider fees below the workers' compensation fee schedule.

You defeated a provision to reduce physician reimbursement by \$5 for outpatient services in the MA program.

Details about these and a number of other successes for Minnesota physicians can be found in the June issue of *The Monitor* and *The Monitor In Brief*, or by contacting the MMA at 800-999-1875.

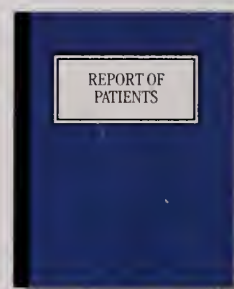
 **MMA**
Minnesota Medical Association

WHEN TODD PETERSON PACKED HIS BAGS, HE LEFT SOMETHING BEHIND.



Todd Peterson became ventilator dependent following a traumatic motor vehicle accident. When Todd was deemed "unweanable" his family was told that he would live the rest of his life on a respirator. But so were Mrs. Moretti with chronic lung disease and Stephanie MacNeal battling a subarachnoid hemorrhage.

That's before HealthEast Bethesda Lutheran Hospital and Rehabilitation Center changed their lives. 30% of our patients considered unweanable were not only weaned, they packed up for home.



Call for our
white paper report and
updated statistics

Scope of services: General Medical Services • Ventilator/Respiratory Care • Wound Care
Neurobehavioral Services • Rehabilitation Inpatient Services • Swallowing Disorder Treatment
Capitol Heights Respiratory Residence • Geriatric Behavioral Care • Pain Management at
the **Minnesota Pain Center (MPC)**, located at HealthEast Bethesda Lutheran Hospital
and Rehabilitation Center, 559 Capitol Boulevard, St. Paul, MN 55103

For more information
Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS



12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession, PA 15261-0001
Pittsburgh, PA 15261-0001

MAYO INVESTS
in the FUTURE

SEPTEMBER 1995

WE SAVE THESE HOSPITALS A LOT OF OPERATING EXPENSES.



THESE HEALTH CARE EXPERTS KNOW THAT THE ENERGY EXPERTS ARE AT NSP.

- Abbott/Northwestern Hospital
- District Memorial Hospital
- Family Practitioners, P.A.
- Health One Mercy Hospital
- Health One Unity Hospital
- Immanuel - St. Joseph's Hospital
- St. Cloud Hospital
- Memorial Blood Center of Minneapolis
- MinnHealth, P.A.
- North Memorial Medical Center
- Northwestern Prosthetics & Orthotics, Inc.
- Park Nicollet Medical Center
- University of Minnesota Hospital and Clinic
- Community Memorial Hospital - Winona



NSP Energy SolutionsSM For Business
1-800-481-4700

Hospitals are looking for ways to cut costs and maintain patient comfort and service. And the energy experts at Northern States Power Company are helping them do it.

We can help you with bottom-line savings, by helping you make your lighting, HVAC and other systems more energy efficient.

Our proven service programs...including discount

rates, audits and cash rebates...are based on years of experience. They're designed to help you save energy, cut costs and maintain the comfort of your patients. That's why when you're selecting an "energy partner," there's just one choice: the energy experts at NSP.

ENERGIZE
Your Bottom LineSM

SEP 18 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover photo of the Mayo Building by Peter Beck.

DEPARTMENTS

5 EDITOR'S NOTEBOOK

51 NEWS CLIPS

61 CME IN MINNESOTA

63 CLASSIFIED ADS

68 INDEX TO ADVERTISERS

FACE TO FACE

- 6 TAKING THE HELM IN TURBULENT TIMES** J. P. Miller
Michael Murray, M.D., assumes the MMA presidency amid national budget cuts and tumultuous local health care reform.

PERSPECTIVES

- 8 KINDER, GENTLER, AND LOWER-PAID WOMEN PHYSICIANS** Patricia Braus
Do women physicians choose to earn less than their male colleagues?

COVER STORY

- 10 INVESTING IN THE FUTURE** J. P. Miller
Mayo Clinic banks on more than reputation in an increasingly competitive health care industry.

PUBLIC HEALTH REPORTS

- 20 TALKING TO YOUR PATIENTS ABOUT GUN VIOLENCE AND GUN SAFETY** Shari Hamilton
Physicians can help prevent death and injury from firearms by providing patients with practical advice.
- 25 SAFE HUNTING** Harris Mills
This DNR conservation officer offers safety tips that physicians can share with patients who hunt.

CLINICAL & HEALTH AFFAIRS

- 29 THE INCIDENCE AND PREVALENCE OF NONFATAL GUNSHOT WOUNDS IN MINNESOTA** Gary Riestenberg, M.S., and Douglas D. Brunette, M.D.

MEDICINE LAW & POLICY

- 43 REPORTING OBLIGATIONS UNDER THE VULNERABLE ADULTS ACT** Sheva J. Sanders, J.D.
Changes to the Vulnerable Adults Act increase the instances when physicians are required to report maltreatment of vulnerable adults.

BOOK REVIEW

- 49 A DREAM FULFILLED** Barbara P. Yawn, M.D., M.Sc.
Dr. Mary Rowland's memoirs tell the intriguing tale of a 19th century woman's struggles and triumphs as a frontier physician.

33 *The Monitor*

HIGHLIGHTS • Resolutions to MMA House of Delegates • MMA objects to sexual misconduct report

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association
Editor-in-Chief
Charles R. Meyer, M.D.
Managing Editor
Meredith McNab
Associate Editor
Susan Rodsjo
Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.
Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993
Richard L. Reece, M.D.
1975-1990
Reuben Berman, M.D.
1971-1974
Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1994-95 Officers

President
Andrew J. K. Smith, M.D.
President-Elect
Michael J. Murray, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Raymond G. Christensen, M.D.
Secretary
Thomas B. Dunkel, M.D.
Treasurer
Erick Reeber, M.D.
Speaker of the House
Barbara P. Yawn, M.D.
Vice Speaker of the House
Anthony C. Jaspers, M.D.
Past President
C. Randall Nelms Jr., M.D.
Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Charles S. Winjum, M.D.
N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.
N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.
West Metro
Roger W. Becklund, M.D.
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.
East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.
S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.
S.E. District
David C. Herman, M.D.
Peter Amadio, M.D.
Noel R. Peterson, M.D.
Resident Member
Scott Stafford, M.D.
Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.
AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair
AMA Alternates
Theodore L. Fritzsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
C. Randall Nelms Jr., M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

Chief Financial Officer
George C. Lohmer Jr.
Director of Legal Affairs
Patricia L. Franklin, J.D.
Director of Legislation and Public Policy
David Renner
Director of Communications
Mark S. Vukelich

CME ACTIVITIES

Sponsored by the University of Minnesota and Hennepin County Medical Center.

Programs are designed for physicians' continuing education credit
and other specialty education credit.

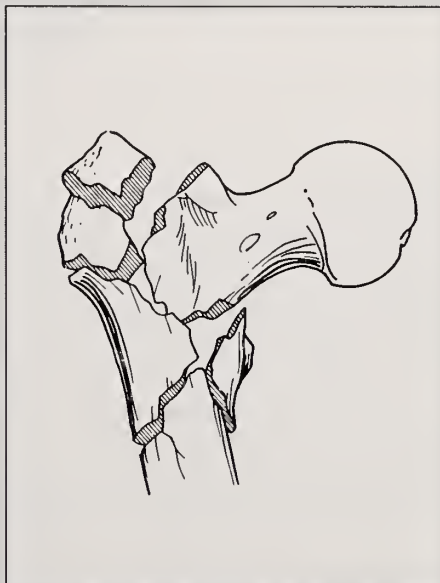


Contemporary Issues in Hemodialysis

Primary Audience: Physicians in Internal Medicine, Nephrology, Endocrinology and Renal Transplant, Nurses, Social Workers, Pharmacists, and Dietitians involved in renal patient care.

September 15, 1995

Sheraton Midway Hotel, St. Paul • Chairs: Robert Berkseth, M.D. and Charles Smith, M.D. • This program will address key factors in measuring and improving the quality in ESRD care, as well as critical points in the evaluation of the renal transplant donor. Symposia include Nutrition, Evolving Technologies, Renal Transplantation and Clinical Nephrology. • 7.0 Credit Hours



Hennepin County Medical Center Orthopaedic and Trauma Seminar

Primary Audience:

Orthopaedic surgeons, PA's, residents and fellows.

October 12-14, 1995

Hennepin County Medical Center, Pillsbury Auditorium,
Minneapolis • Chair: Richard Kyle, M.D.

State of the art Orthopaedic care.

16.25 Credit Hours

Research Statistics: A Two Day Primer • September 14-15, 1995

(Limited attendance) • Primary Audience: All physician specialties • Chair: Al Pheley, Ph.D.
Will provide theoretical and computational background on the most common medical research statistics.
12.25 Credit Hours

State of the Art in EMS • September 29-October 1, 1995

Primary Audience: Ambulance service medical directors • Chairs: Dan Hankins, M.D. and Timothy Crimmins, M.D.
13.0 Credit Hours

Forensic Science Seminar • October 5-6, 1995

Primary Audience: Medical examiners, County coroners, law enforcement, legal personnel • Chair: Garry Peterson, M.D.
13.50 Credit Hours

Family Practice Update • December 1, 1995

Primary Audience: Family physicians • Chair: Charles Anderson, M.D.
6.0 Credit Hours

For registration/brochure/or more information:

Gina Conklin

HC MC Office of Academic Affairs • 701 Park Ave., Mail Code 869-A • Minneapolis, MN 55415 • (612) 347-2075, FAX (612) 347-2154

FAMILY PRACTICE OPPORTUNITIES

HealthPartners

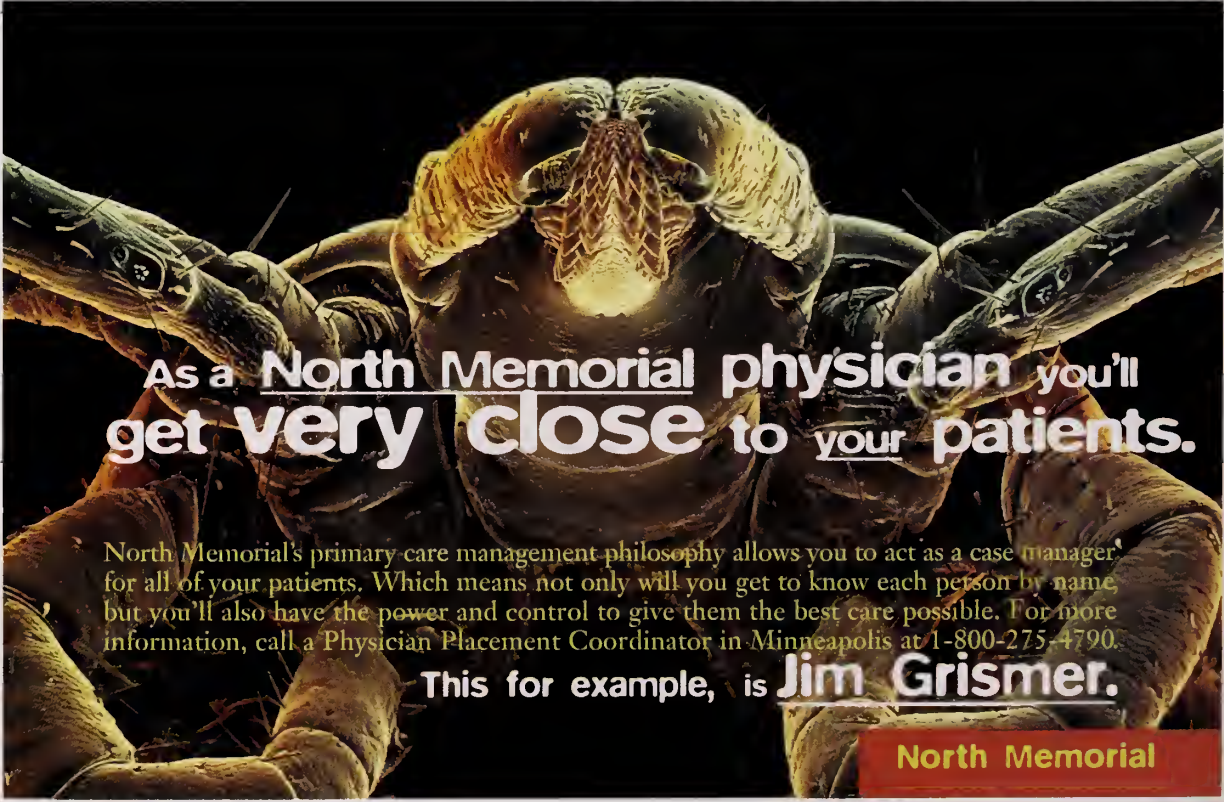
HealthPartners offers excellent family practice opportunities for BC/BE family practitioners. HealthPartners, a staff-model HMO, offers its physicians excellent salaries, generous benefits, a balanced lifestyle with practice scheduling flexibility, and the opportunity to practice medicine without the headaches of managing an office.

The Family Practice Department is staffed by over 75 BC/BE physicians and offers a broad range of full-range and limited-range practice options.

To inquire about specific opportunities, please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Avenue South, PO Box 1309, Minneapolis, MN 55440-1309.



HealthPartners' mission is to improve the health of our members and our community.



As a North Memorial physician you'll get **very close** to your patients.

North Memorial's primary care management philosophy allows you to act as a case manager for all of your patients. Which means not only will you get to know each person by name, but you'll also have the power and control to give them the best care possible. For more information, call a Physician Placement Coordinator in Minneapolis at 1-800-275-4790.

This for example, is **Jim Grismer**.

North Memorial

The Mayo Mythology

Charles R. Meyer, M.D.

It's tough being a legend. Whether you're Muhammed Ali or General Motors, success brings fame, but also the expectation of continued success. Medicine has its individual legends—Osler, DeBakey, Salk. A few institutions like Massachusetts General and Johns Hopkins also qualify. For name recognition and near unblemished reverence, few rival the Mayo Clinic. For almost a century, the house that Will and Charlie built has been a mecca of quality medicine. But as Muhammed Ali knows, you've got to defend your title. The rearranging of health care during the last 10 years has threatened the patient base that feeds tertiary institutions like Mayo, issuing an inescapable challenge. This month's cover story looks at how Mayo is meeting that challenge.

A catalyst for examining Mayo is the installation of Michael Murray, M.D., as president of the Minnesota Medical Association at the Annual Meeting in September. An anesthesiologist from Mayo, Murray is profiled by J.P. Miller (page 6). A companion article by Miller analyzes the threats to Mayo in the current health care miasma and what the Rochester institution is doing to maintain its legendary status (page 10).

Will Mayo's success continue? First, a personal reminiscence. My ties to the Mayo Clinic are professional and personal. I did a three-year internal medicine residency there. I also lived for those three years in the gardener's house on the Charles Mayo estate, Mayowood. During my training, I found a dedication to conservative, quality medical care and unrivaled educational opportunities. It was a marvelous place to train. Mayowood offered a tranquil taste of Mayo's history.



"The rearranging of health care during the last 10 years has threatened the patient base that feeds tertiary institutions like Mayo."

When I left in 1977, Mayo's thriving business was much as it always had been: a steady stream of worldwide referrals added to a solid base of regional patients.

But the bounty of 1977 might have dried up. Exploding managed care has restricted patients' access to physicians, introduced capitated contracts (which discourage referral), and driven fees down. Patients who wanted to come to Mayo couldn't get their care covered. Doctors who wanted to refer feared eroding capitation pools. Patient-generated income streams dwindled.

So what has Mayo done? Secured its traditional regional patient base by acquiring regional clinics and by cooperating in ventures with regional institutions. Expanded its patient catchment with the Scottsdale and Jacksonville campuses. Played the game of managed care by

allying with existing plans and establishing its own local health plan. And expanded revenue opportunities through Mayo Medical Ventures. Each move has been insightful, planned, and physician-led.

Mayo's strategic advantage for future success is the same that has made Mayo a famous, squeaky-clean four-letter word. 1) Organization: The clinic and its hospitals are a well-oiled machine whose efficiency is awesome. Charts stay arranged, endless patient appointments smoothly interlock, and x-rays magically appear where they're needed. 2) Work ethic: Mayo draws dedicated employees, many from southern Minnesota. I met dental x-ray technicians who had been doing dental x-rays for 30 years. 3) Physician collegiality: The physician staff is mostly Mayo-trained. During training, you learn that cooperation works. 4) Physician leadership: Smart administrators are important, but the Will and Charlie tradition of direction by M.D.s persists, and patient care matters most.

I used to cross-country ski a Mayowood trail across the road from our Rochester house. The trail passed by Mayowood. I frequently paused and looked up the hill at the majestic mansion. Maybe it was the eerie quiet of the snow-covered woods, but I sometimes imagined Charlie Mayo strolling on the porch. The spirit of both Mayo brothers has always haunted the Mayo Clinic, benign spirits constantly urging their descendents to continue the pursuit of quality medicine. Even legends need legendary examples to follow if they are going to succeed. I think Mayo will.

MM

Taking the Helm in Turbulent Times

Exhibiting the same calm confidence with which he treats patients, Michael Murray, M.D., assumes the MMA presidency amid national budget cuts and tumultuous local health care reform.

J. P. Miller

Somewhere in the vast labyrinth of Mayo Clinic Rochester, one of Dr. Michael Murray's colleagues is waiting to discuss a textbook they're co-writing. A few feet away from Murray in the dimly lit surgery prep room, a nurse and a journalist, both outfitted in blue scrubs, are standing by for some of his time. In the meantime, Murray's beeper cuts with startling clarity through the quiet hum of rushing staff and patients' rustling sheets. But the anesthesiologist is oblivious to it all.

Standing over the elderly patient's bed, Murray's lanky 6-foot-8-inch frame is attuned to the woman's condition and her fears. The chart Murray scans shows the woman will have relatively minor surgery on her hand, but, despite her confident tone, she is frightened. Her one good hand rests tensely by her right side, her fingers crossed. Murray knows that something more than his clinical expertise is needed. He lightens the atmosphere with a little conversation, first with routine medical questions and then with queries designed to stir more pleasant emotions.

"Where are you from?" elicits a curt reply: She names a Wisconsin town. "What's there?" gets a brief, noncommittal answer. Finally, his "A lot of good people, I bet," gets a smile.

When Murray takes the helm of the Minnesota Medical Association as incoming president later this month, he says he'll need great quantities of the same skill he used to calm the worried woman: as Murray puts it, "communication, communication, communication." The organization of which he'll assume leadership a few days short of his 46th birthday is coming off a whirlwind year of legislative activity, most of which ended positively. Yet even with the political victories under its belt, the association faces numerous uncertainties as it moves into 1996. In Minnesota, the line between health care providers and insurers is becoming blurrier as both rapidly acquire clinics and forge closer ties. The long-term effects of MinnesotaCare are unclear. Nationally, deep cuts in Medicare and Medicaid reimbursements are possible as a Republican Congress moves to enact its agenda.

"I think the pace of health care reform has slowed and, in a way, it's anticlimactic to become president after everything that happened in the Legislature," Murray says. "Still, there's a lot of work to be done."

As president of the association, Murray believes one of his most important priorities is education—more specifically, explaining the changing roles and expectations of physicians and the public as reforms become reality. Also crucial is the role of industry monitor. "As changes seep through health care, ensuring that these changes result in better care becomes increasingly important," says Murray. In his leadership role, he



Michael Murray, M.D.

landed on the moon. As Murray and several friends watched the lunar walk on TV, Murray was talking with someone in the room who was a chemist. Murray disliked what he heard about the man's job and started thinking he didn't want to work for a large chemical company the rest of his life.

"I wanted something more," he says. Two of his friends were pondering careers in medicine. At first, he thought they were crazy, considering the long hours and years of training. Then, as the flickering images of astronauts went off the air, Murray says he saw the possibilities of a career in medicine. More important, he saw a place for himself and his skills.

Following graduation in 1971, Murray attended Baylor College of Medicine in Houston, Texas. He graduated in 1976 and received a Ph.D. in physiology from Baylor a year later. But Murray didn't spend all those years in Texas. From 1973 to 1974, he trained at medical schools in Great Britain and France. Part of his motivation was a desire to gain additional training in the care of patients with neurologic and cardiovas-

cular diseases. But equally important was his interest in other cultures. After an immersion class in the French language, Murray studied at a medical college in Lyon, France.

He returned to the United States with a global perspective on medicine. He's found this a valuable reference point as the American health care system evolves. "It really comes down to technology versus nontechnology," he says, contrasting the European and U.S. cultural views of medicine. "[Europeans] have almost a fatalistic approach to life. They don't have the belief in technology that we do. I don't think you can understand that if you haven't been there."

Despite a continuing wanderlust, Murray has found a home in Minnesota. From 1976 to 1977, he interned at Mayo Clinic and then served as a lieutenant in the Indian Health Service at a reservation in

MURRAY continued on page 58

believes he has the ability to study key issues in the industry and then draw attention to them through the public spotlight that comes with his position. During his year in office, Murray sees himself traveling extensively to meet with both doctors and the public. Fortunately, his life thus far has prepared him well for a year on the road.

Ask him where he's from, and Murray's answer is "Nowhere." His father worked for chemical giant Union Carbide. The job meant the family seldom stayed in one place for long, with moving vans arriving just as the family settled in. But that lifestyle had its benefits, Murray says. It was an education in itself. And over the years, it imbued him with a curiosity about the world and the confidence to see the world for himself.

Murray attended St. Benedict's College in Atchison, Kansas, majoring in chemistry. His plans to become a chemist ended as astronaut Neil Armstrong

Kinder, Gentler, and

Lower-Paid Women Physicians

By Patricia Braus

*Women physicians
earn less than
their male colleagues,
but is it by choice?*

Female health care practitioners have made progress since the days of Florence Nightingale, but women physicians still earn much less than their male counterparts. The choices they make account for some of the earnings difference, but continued discrimination is another reason.

As Americans struggle to change their health care system, the emerging prominence of women in medicine is already making a difference. While they may become more like male doctors as they gain tenure and power, the secondary positioning of women in the profession—whether caused by their own altruism and career choices or by involuntary bias—could help reduce the cost of health care, increase the availability of much-needed primary care physicians, and change the way medicine is practiced.

Women, who made up 42 percent of applicants to U.S. medical schools in 1992, make less money than their male counterparts for several reasons. They spend more time with patients. They are more likely to work for a salary. They are more likely to work in lower-paid primary care specialties.

While lower physician incomes for women may not be “fair or right, if you’re interested in controlling health care costs ... it may be possible to reduce physician income with more women in the profession,” says Steven Martin, M.D., an internist and medical historian at the Albert Einstein College of Medicine.

That suggestion—that female physicians are somehow destined to be cheaper labor than men—makes Jane Schaller, M.D., bristle. When she graduated from Harvard Medical School in 1960,

she was one of six women in a class of 150. “People were nice to us, but we were referred to as ‘gentlemen.’ ” Thirty-five years later, she is chair of the pediatrics department at Tufts University School of Medicine.

“There’s a concern that women lower the economic standards of the profession because they’re willing to work for less. I think that’s faulty reasoning. Women want to succeed.”

The heroine of the TV show “Dr. Quinn, Medicine Woman” may seem like an anomaly. Few associate the Old West of the 19th century with independent career women. But women have always played a major role in U.S. health care (see related book review, page 48).

Dorothea Dix, best known as a mental-health reformer, led a squad of female nurses in the Union Army during the Civil War. By the late 19th century, the United States was a world leader in the training of female doctors, according to Mary Roth Walsh, a psychologist and author of a history of medical education.

But in the early 20th century, women became a rarity in medical schools when a review of the educational system closed many medical schools that had served them. According to Walsh, there were fewer female physicians in Boston in 1950 than there had been in 1890.

Female doctors became more common with the feminist movement and affirmative action in the 1970s. Medical schools once again altered their admissions policies and encouraged women to apply.

The number of female physicians in the Unit-

ed States increased 310 percent between 1970 and 1990, from 25,400 to 104,200, according to the American Medical Association (AMA). In 1990, women accounted for about 20 percent of U.S. physicians, up from 13 percent in 1980.

But although women and men are challenging traditional divisions in health care, most specific professions remain dominated by one sex. Women are disproportionately located in lower-paid specialties. At least 90 percent of registered nurses, speech therapists, and occupational therapists are women, according to tabulations from the 1990 census by Claritas.

Women are also more likely than men to be dietitians, physical therapists, and respiratory therapists. Men are more likely than women to become physicians and to enter other higher-paying fields, such as podiatry, dentistry, optometry, and pharmacy.

The average woman in medical practice is younger than the average man in practice, so one would expect women doctors to earn less. The net income of female physicians averaged 62 percent of the net earned by men in 1992, according to the AMA. The figure is even lower (59 percent) for women who have been practicing for five to 19 years. It is higher for women who have been practicing medicine for 20 or more years, but these experienced doctors still earn just 72 percent as much as their male peers. Female physicians earned an average of \$117,500, compared with \$188,600 for men.

Women earn less than men partly because they work fewer hours. Female physicians worked an average of 55 hours a week in 1992, according to the AMA, compared with 61 hours for men.

ILLUSTRATION BY TRACY TURNER



Doctors usually don't get paid by the hour, but those in private practice get paid according to how many patients they see. Fewer hours tend to translate into fewer patients and less money, and numerous studies show that women spend more time with each patient, says Martin. Male physicians made 117 patient visits per week in 1992, compared with 97 for women.

Gender-specific preferences in type of practice also play a role in female doctors' lower earnings. The AMA reports that female physicians are about twice as likely as men to be employed by a hospital, HMO, group practice, or other organization.

Forty-three percent of women doctors are employees, compared with 22 percent of men. Just 57 percent of women doctors work alone, with a partner, as part owner in a group practice, or as an independent contractor. For men doctors, this share is 79 percent.

While independent practitioners generally earn more money, they also tend to work longer hours

WOMEN PHYSICIANS continued on page 60

INVESTING *in the* FUTURE

By J. P. Miller

Mayo Clinic banks on more than reputation in an increasingly competitive health care industry.

The two-page press release from Mayo Clinic didn't garner any headlines last April when it was faxed to media around the nation. The simple statement that Mayo would improve its operating efficiency by installing an electronic records-keeping system didn't get much attention. The release merited a news brief or two in regional papers, and then was forgotten.

But veteran Mayo watchers knew better and saw the announcement for what it was: a clear indicator of the deep



PHOTOGRAPH BY PETER BECK

changes underway at the world-renowned medical center. It's not obvious at first, but a new record-keeping system means Mayo is moving beyond one of the institution's most treasured and effective traditions—the unique and far-sighted records transportation system designed by Henry Plummer, M.D., in the 1920s. Consisting of conveyor belts, pulleys, and interconnecting tubes, the system shuttles patients' records from doctor to doctor and has been regarded with something close to reverence throughout Mayo's history. Plummer, after all, was declared a genius by Will and Charlie Mayo, and the famous art deco Mayo building in downtown Rochester is named for the eccentric physician.

As the rapidly evolving health care industry forces changes on providers across the nation, perhaps nowhere does it collide in such a head-on fashion with institutional tradition as it does at Mayo. Since the days when surgical antisepsis was considered cutting edge, the Mayo name has attracted millions to Rochester by reputation alone. Included in those millions were some of the world's best doctors and scientists. Doted on by the press and politicians, the simple clinic became something more—an institution whose famous founders, movie star patients, and vast financial resources meant it could well afford an ivory tower attitude and cherished old-time conventions.

But the days of relying on Mayo's reputation have been over for some time. Since the 1980s, price controls, declining hospitalization rates, and the growing power of third-party payers have forced changes on all providers. Mayo has been no exception, according to its physicians and administrators. As a tertiary care provider, Mayo has watched with alarm as insurers and others moved to cut costs by restricting patients' access and by demanding capitated fees. Declining Medicare reimbursements have also dealt a blow to medical centers' bottom lines.

In 1993, all these factors showed themselves in Mayo's financial health for the first time in its history. In November 1993, Mayo officials announced that Mayo would postpone indefinitely the construction of a new \$35 million building in downtown Rochester. And though the center posted a record number of patients in 1993, its annual report showed Mayo lost \$6.2 million in patient care operations for that year. In 1994, patient care was again profitable and is expected to be in 1995, according to Mayo officials. Still, the same trends that affected Mayo two years ago continue, Mayo officials say. And if anything, the rate of change in the health care industry has quickened.

That leaves Mayo with a dilemma: how to survive in an increasingly competitive industry while maintaining its traditions of research, education, charity, and most important, quality care. Like the Plummer record system, officials say, Mayo's traditions must be improved upon if Mayo is to maintain its world-class reputation.

"It's going to take a lot of work," says Richard Tompkins, M.D., a rheumatologist and member of Mayo's Regional Strategy Work Group. "We can't just sit in Rochester and have everyone come running to our door."

Adds Patricia Simmons, M.D., pediatrician and member of Mayo's Board of Governors: "For us to stay in the lead, we need to keep moving. We can't sit back and rest on our laurels."

Much of the responsibility for moving Mayo into the future is being shouldered by physicians. Simmons and Tompkins are just two of the many doctors who staff committees directing strategy for everything from marketing to disease management protocols. Administrators also typically have a medical counterpart. At Mayo Medical Ventures, for example, lead administrator Rick Colvin is paired with Richard Brubaker, M.D., an ophthalmologist who also acts as MMV's medical director. Tompkins is the medical director of Mayo Management Services Inc., a subsidiary for processing claims headed by administrator Al Schilmoeller. Historically, Mayo's emphasis on collegiality has always brought physicians into the decision-making process, says Clark Nelson, retired Mayo historian. That's even more true today, says Mayo Foundation Chief Executive Officer Robert Waller, M.D. This involvement is an important difference between Mayo and its competitors, Waller says. It's also a reason Mayo will maintain its high standards in the coming years.

"We will develop practice guidelines, disease management strategies, critical pathways, outcomes research, and accountability for cost, quality, and patient satisfaction. The important distinction is that the people who will be working on these projects are the ones engaged in the practice," Waller has said in the past. "These kinds of activities are clearly excellent investments in the future."

"For us to stay in the lead,
we need to keep moving.
We can't sit back and rest
on our laurels."

—PATRICIA SIMMONS, M.D.

Affiliating With Regional Providers

The Regional Strategy Work Group has played a key role in one of Mayo's most visible moves to position itself: affiliations with regional clinics. Since the early 1970s, physicians have met under various auspices to consider a regional network. For more than a decade, those discussions were theoretical, and the group disbanded in 1981. But changes in the coming years demanded action. In 1990, the disbanded group was called together again, this time under the regional strategies name. Chaired by Michael O'Sullivan, M.D., a specialist in laboratory medicine and pathology, the group quickly understood its mission: Make sure patient choices include Mayo.

"It doesn't matter how good we are if they can't come to Mayo," says work group member Tompkins.

The group rapidly decided Mayo must form its own network to preserve this option for patients, according to O'Sullivan. With about half of Mayo's patients coming from within a 120-mile radius of Rochester, group members decided upon a strategy of affiliating with

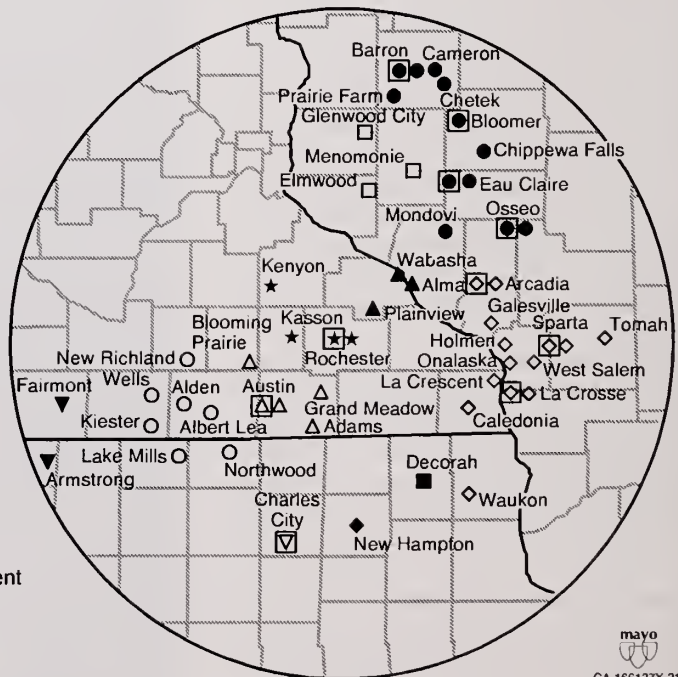
clinics in that area. The goal: a "Mayo-friendly facility" within a half-hour's drive from anywhere in the circle. By 1992, the group's plans had resulted in a merger of Mayo and Luther Hospital and Midelfort Clinic in Eau Claire, Wisconsin. Three years later, almost 350 physicians have been added to the Mayo regional health system, O'Sullivan says. And with affiliations in Eau Claire and La Crosse, Wisconsin; Decorah, Iowa; and pending negotiations with Mankato's Immanuel-St. Joseph Hospital, Mayo appears to have established itself as the predominant health care network in the region. Mayo also has affiliated with numerous smaller clinics in Minnesota, Iowa, and Wisconsin (see chart below).

"Their first priority was to maintain the integrity of their borders," says George Halvorson, CEO of HealthPartners, the parent company of Group Health and MedCenters Health Plan in the Twin Cities. "And they've done that. If you take a look at who Mayo owned and operated outside of Rochester two years ago and then you look at it today, the job they've done is very impressive."

Mayo Health System

- Luther-Midelfort Medical Center, Eau Claire, Wisconsin
- Decorah Clinic, Decorah, Iowa
- ▲ Wabasha Clinic, Wabasha, Minnesota
- ◆ New Hampton Clinic, New Hampton, Iowa
- ▼ Fairmont Clinic, Fairmont, Minnesota
- ★ Kenyon-Mayo Family Practice Clinic, Kenyon, Minnesota
- ★ Kasson-Mayo Family Practice Clinic, Kasson, Minnesota
- Albert Lea Clinic, Albert Lea, Minnesota
- Red Cedar Clinic, Menomonie, Wisconsin
- △ Austin Medical Center, Austin, Minnesota
- ◇ Franciscan Skemp Healthcare, La Crosse, Wisconsin
- ▽ Floyd County Memorial Hospital (Management Service Agreement), Charles City, Iowa

Symbol + □ = Hospitals
Symbol = Clinics



mayo
CA-166137X-21

As *Minnesota Medicine* went to press in August, Mayo announced plans to develop the Cannon Valley Clinic in Faribault, Minnesota.



"It doesn't
matter how
good we are
if patients
can't come
to Mayo."

—RICHARD TOMPKINS, M.D.

then lead negotiations with local physicians. Also on the table are Mayo quality standards. "We spend long hours discussing ethics, values, and our set of principles," O'Sullivan says. "Probably 90 percent of our effort goes in that direction."

Mayo officials will reveal little about the structure of its numerous affiliation agreements,

The affiliations came none too soon, adds Halvorson. As Mayo negotiates an agreement with the Mankato hospital, competitors are moving into the area O'Sullivan's group designated as critical to Mayo's future. In July, Allina announced the acquisition of a clinic in Faribault. And other large Twin Cities providers have announced plans to expand in south-central Minnesota.

O'Sullivan and Peter Carryer, M.D., also a member of the Regional Strategy Work Group, acknowledge the growing competition, but say Mayo's tradition of physician involvement gives it an advantage over competitors moving into the region. "The fact that we are physician-led is a strong selling point," says Carryer, a gastroenterologist.

This tradition also has strongly influenced the affiliation process and the operation of clinics after they've merged into Mayo's growing network, according to Carryer. Teams of physicians and administrators are sent to investigate potential new affiliates. At the same time, the community in which the clinic is located is surveyed to determine attitudes about Mayo and the quality of care provided by the local clinic. Financial records of the clinic are also analyzed. Mayo physicians

or what kind of financial transactions take place. But in one of its most recent affiliations, with Franciscan Health System and Skemp Clinic in La Crosse, Wisconsin, Mayo made available \$14.6 million to the newly merged and Mayo-affiliated Franciscan Skemp Healthcare system, according to Brian Campion, M.D., the system's president. The money was used to acquire the medical centers' existing accounts receivable and assets, and also to help implement a business plan for the future. The merger became effective in July. The governing structure of the new La Crosse system is also a hallmark of how Mayo operates its other affiliated clinics. In Eau Claire, Decatur, and other Mayo affiliates scattered across the region, much of the day-to-day operations are left to local control. The same is true in La Crosse, Campion says. In addition, the La Crosse system's administrators and physicians are given much say in deciding the organization's broader direction. For example, the Sisters of Perpetual Adoration, the founding Catholic sponsors of the former Franciscan Health System, retain approval rights over who is appointed to the newly merged system's board of directors. Two-thirds of the board consists of La Crosse residents. Five Mayo physicians also sit

on the board, including O'Sullivan.

"Mayo's very strong physician orientation and leadership ... provided an enormous amount of reassurance to us," says Champion, whose Franciscan Health System faced financial difficulties in the mid-1980s. "I know no single way is perfect, but I'd much rather be doing this than be an employee of an insurance company."

O'Sullivan responds, "We believe that physicians as professionals will be motivated if they have significant impact on their own destiny. ... We have seen other systems where physicians are taken on in an employee situation. That is not the type of system we want to be part of."

Not everyone was as pleased with Mayo's La Crosse affiliation, however. Soon after negotiations between the two were announced in November 1994, founders of another La Crosse medical center heavily criticized the affiliation. Sigurd Gundersen, a member of the family that founded Gundersen Clinic, told local media that Mayo was trying to siphon off La Crosse patients to Rochester. This, Gundersen said, would weaken the Wisconsin city's medical centers. Gundersen also resigned in protest from the Roman Catholic-affiliated Viterbo College board of directors. At the same time, Gundersen Clinic curtailed its practice of sending specialists to see Skemp patients. Gundersen Clinic, it should be noted, had pursued an affiliation with Skemp Clinic and Franciscan Health System.

Collaborating With Private Industry

Though affiliation announcements have been rapid and numerous over the past several years, O'Sullivan says the pace will slow considerably in the coming months. "We feel the major components are in place," he says. The focus now, say Mayo officials, will likely be agreements with private industry.

Mayo already has made significant strides in that direction. In 1992, Mayo joined with Park Nicollet Medical Center and two Twin Cities insurance providers to form the Institute for Clinical Systems Integration. That organization's influence, Mayo sources say, helped all four put together a contract with the Business Health Care Action Group of Minnesota, a consortium of 14 (now 23) large Twin Cities employers. Mayo is now the preferred provider for the consortium's approximately 250,000 insureds and dependents when highly specialized care is needed. In 1993, Mayo collaborated with tractor manufacturer John Deere to design a health plan and system to control Deere's spiraling employee health care costs. Mayo is now one of the designated referral centers for Deere employees when specialty care is needed.

Thanks in part to the favorable publicity generated by the Deere collaboration, Mayo's agreements with private industry have been quickly expanding, according to Al Schilmoeller, chair of Mayo's Division of Managed Care and Regional Programs. HealthPartners, Preferred One, and Blue Cross and Blue Shield in Iowa, Minnesota, and Wisconsin have made Mayo a designated referral center for highly specialized care. HealthPartners also has collaborated with Mayo to form Mayo Choice-HealthPartners, a plan that allows enrollees to come to Mayo without a referral, provided they pay 20 percent of the visit's cost. About 16,000 people have enrolled in the plan since it was announced in mid-1993.

"The name of the game is patient access, and to have that, you have to be in all those networks," Schilmoeller says.

Mayo has also worked with several private companies to develop managed care products. In the fall of 1994, Mayo designed a managed health care plan for IBM Rochester's 4,000 employees at the company's request. Under the plan, dubbed Mayo Choice-A Health Plan For IBM, employees choose a primary care location from the plan's network of providers. Mayo is the designated referral center and administers the plan and processes claims. No insurance company is involved. Since the plan was offered January 1, about half of IBM Rochester employees have enrolled. A similar arrangement is in effect with American Express in Scottsdale, Arizona, where one of Mayo's two other campuses is located. Negotiations for more such arrangements are underway with other companies.

"Every chance we get, we'll write contracts with people to allow their people to come here for high-tech kinds of health care," vows Tompkins.

Developing Protocols

Mayo's work in developing disease management strategies will likely help it land more contracts with industry and insurers, Mayo sources say. Disease management strategies, which designate a treatment pathway for a medical condition, help insurers and providers walk the fine line between quality care and lower costs. Mayo has made significant strides in developing such strategies for about 25 conditions. An equal number are in the works. Several companies, including Aetna Life and Casualty, have paid Mayo to develop guidelines for various medical conditions.

Exactly why insurance companies are attracted to Mayo's disease management protocols can be seen in the Rochester center's liver transplant program. Since 1985, Mayo has performed more than 600 such transplants. At



"The name of the game is patient access, and to have that, you have to be in all those networks."

—Al SCHILMOELLER

Steers estimates the protocols have saved Mayo at least \$600,000 since they were implemented more than 200 transplants ago. That type of savings, and the increasing survival rate, give Mayo an advantage when competing against other specialty centers to become insurers' designated provider for high-tech operations, Steers says. "The cost

the same time, it has reduced costs significantly while improving its survival rate. While part of that success can be attributed to increasing expertise, some of the credit is due to the disease management protocols used by the program, according to Jeffrey Steers, M.D., a liver transplant surgeon.

Steers acknowledges that much of the reason for such protocols is the push to contain costs. But Mayo's emphasis on physician involvement has made the protocols a tool to achieve better care, not lessen it, he says. Physicians, assisted by statistician Roger Evans and Mayo's Section of Health Services Evaluation, were the ones who whittled down the screening tests "to the bare minimum," Steers says, and then rigorously evaluated everything else. Analysis revealed that several tests could be performed much earlier after the operation than previously thought. This decreased transplant hospital stays, which hovered between 14 and 17 days before the protocols, to seven to 10 days after the protocols were enacted. In addition, after scrutinizing transplant procedures, surgeons modified the procedures by placing a biliary tube that is significantly less likely to cause postoperative complications.

focus has resulted in better care. It's also been good for Mayo at the same time." But disease management protocols haven't always been easy for physicians to accept, Steers says. Although many physicians acknowledge that protocols are a good policy, some are reluctant to give up their individual ability to direct care of patients. "I can understand that feeling, but at the same time, these protocols provide consistent care that can be modified as necessary for the patient," he says. "The [protocols] are not inflexible, but they do make you stop and think, 'What is the reason for doing this, and is it necessary for the patient?'"

Bolstering Revenue Through Medical Ventures

Other changes at Mayo have focused more specifically on the bottom line than on patient access. Still, they, too, contribute to the changing Mayo culture.

In 1985, the Rochester medical center formed Mayo Medical Ventures, a subsidiary whose function is to bring Mayo resources to the public and, more important, bolster Mayo's revenue from nontraditional sources.

MAYO REACHES OUT TO REFERRING DOCS

Collegiality among physicians has been a Mayo Clinic tradition since the days when Drs. Will and Charlie Mayo oversaw the practice. But sometimes, Mayo doctors and administrators acknowledge, physicians who send their patients to Mayo have felt shut out.

A glimpse of just how far out of the Mayo loop referring physicians have felt arrived in the form of a letter in 1994. Written by an Owatonna physician, the letter noted the death of a patient the physician had sent to Mayo. Though Mayo had a number of procedures in place to notify referring physicians of patients' conditions, apparently the process wasn't fast enough in this case. The physician had learned of his patient's death from the local newspaper—not from the medical center to which he had entrusted his patient.

The letter hit home at Mayo, according to administrator Mark Rieder. "In essence the letter said, 'It sure would have been nice if I would have heard from you.' We agreed and took steps to avoid similar gaps in communication."

In typical Mayo fashion, the medical center's response has been to form committees composed heavily of physicians to both study the problem and implement a solution. Since then, a number of ideas have been put into action.

Soon after the letter, Mayo's marketing committee, led by pediatrician Patricia Simmons, M.D., recommended using focus groups to gather more information from referring physicians. Within months, focus groups were held in Rochester, St. Cloud, and Waterloo.

Though doctors in the groups were asked a variety of questions, their answers inevitably came down to this: a desire for better communication and access, according to Simmons. Physicians wanted more feedback from Mayo about their patients. They also wanted easier access to Mayo, both for themselves and their patients. "They want to be a partner in patient care," Simmons says.

Rieder, who serves on a referring physician services committee, expands on that. Physicians, he says, want phone calls and quick, informal letters that keep them involved in their patients' care. In the past, Mayo's correspondence with referring physicians has tended to be long, formal accounts of everything done to the patients. Because of the

formality, correspondence often took time to prepare and send. But what the referring physician really wants, Rieder says, is rapid information on outcomes and concise guidance on what kind of care the patient will need upon returning to the primary care physician.

Since the letter and focus groups, Mayo physicians and administrators have worked together to improve communications and access for referring physicians. Doctors now understand the need for phone calls or brief letters to referring physicians. Patients' hometown doctors and their phone numbers will soon be listed on the census reports physicians take with them on hospital rounds. In addition, Mayo staff are working on a prototype letter for referring physicians that could easily incorporate patient information from the new electronic medical records system so up-to-date information could be sent quickly to referring physicians.

Other changes have made it easier for referring physicians to gain access to Mayo for themselves and their patients. A new toll-free phone line exists for physicians to make appointments for patients. In the past, doctors calling in were shuffled around the medical center to the correct department—a system that sometimes left patients and referring physicians "hanging," Rieder says.

With the new phone line, the person answering the call takes information from the referring physician and forwards it to the correct department, which will respond to the referring physician's request within 24 hours. Referring physicians can save time by faxing appointment requests and patient information to Mayo.

Referring physicians now have easier access to Mayo specialists, as well. Since 1994, a physician in each department has been designated to take calls from referring physicians to ensure the primary care doctors get their questions answered promptly, Rieder says. In addition, Mayo enacted a new policy in July that forwards calls directly to Mayo physicians without going through secretaries. The point, Rieder says, is that referring physicians get through to a doctor right away.

"It's critical we communicate with the people who send us patients."

—JPM



"Referring physicians
want to be a partner
in patient care."

—PATRICIA SIMMONS, M.D.

"That's the mission of MMV," says David Larson, M.D., a Mayo gastroenterologist and MMV's associate medical director. "The vision is to help people lead more healthful lives by connecting Mayo exper-

rise with the global marketplace. But our mission within the institution is to financially support Mayo's programs." MMV publishes the *Mayo Clinic Health Letter*, the "Mayo Clinic Family Health Book," and several other hardcover titles. It also works with IVI Publishing in Eden Prairie to publish books electronically. More than 1 million "Family Health Book" CD-ROMs have been sold.

MMV also has inked a deal with a cable television network to provide editorial content for shows and graphics. The network, called American Health Network, is based in Orlando, Florida. Mayo is paid for its services through royalty agreements. MMV also acts as a broker for physicians and medical centers requesting

consultative services in medical facilities. Most such requests have come from international sources, Larson says. In Jordan, Mayo consultants are designing a medical education link for King Hussein, who has made many well-publicized visits to Rochester-Mayo. Other countries in Europe, South America, and the Far East have also sought Mayo consultative services. MMV has evaluated more than 100 such requests from 21 different countries in the last year. While the consulting fees bolster the bottom line, according to Larson, they also have the potential to increase patient referrals.

"With all the changes taking place in the U.S., we also want to exert a strong presence outside the U.S. to assist with developing a medical infrastructure, along with generating patient referrals," Larson says.

MMV also operates pharmacies in Rochester and oversees licensing agreements for devices invented by Mayo staff. Since 1985, the number of products MMV licenses has grown from two to almost 200 in 1994. Projected profits for MMV in 1995 are close to \$9 million, a figure that's grown more than 20 percent annually for the past few years. "Our plan shows [profits] continuing to grow at that pace," Larson says. MMV and Mayo's other diversified operations, such as the Gold Cross Ambulance service it purchased in 1994, contributed \$17 million to Mayo's bottom line in 1994.

Forging Profitable Ties With Industry

Elsewhere at Mayo, physicians are working to forge closer ties with industry. That's done primarily through the Office of Strategic Alliances. Formed in 1992, the OSA is headed by administrator Gerald Wollner and Mayo scientist Thomas Moyer, Ph.D. Just 3 years old, the organization has evolved rapidly from merely offering a starting point for industry interested in working with Mayo to playing an active role in relations with health care companies. Wollner and other Mayo representatives now call on industry with whom Mayo is interested in working. In September, Mayo is expected to announce one of the first relationships brought to frui-



"We believe that physicians will be motivated if they have significant impact on their own destiny."

—MICHAEL O'SULLIVAN, M.D.

tion by the OSA: a joint research project on wound healing with a large Minnesota company involved in medical supplies and research. The office also engineered the agreement with Aetna for Mayo's expertise and data in developing disease management protocols for cardiovascular disease. The insurer paid Mayo \$1.3 million in the arrangement. More such relationships are on the way, according to Moyer, and Mayo has investigated the long-term ties between Monsanto and Washington University in St. Louis, Missouri, as a model for its future industrial relations. Monsanto heavily funds much of Washington University's research.

"In an ideal world, researchers would be able to investigate any avenue worth pursuing," Moyer says. "But this isn't the ideal world, and you have to have funding."

Maintaining a World-Class Reputation

After the numerous changes at Mayo in the past few years, one question remains: Are the strategies put in place enough to allow Mayo to keep its world-class reputation and traditional standards of care? Mayo

managed care, with its emphasis on primary care and efficient delivery of the highest quality health care at the best possible price, gains a foothold in our region."

Moyer of Strategic Alliances agrees: "Mayo's long-range goal is really the improved practice of medicine. I think the changes put in place will assist it in doing this, rather than taking away from it."

More objective observers share the Mayo staff's optimism. Halvorson of HealthPartners sees a future in which Mayo dominates the region around it and increases its number of international patients. Though Mayo will likely lose patients from within the United States because of restricted networks, Halvorson says Mayo has planned well for the future. "Of all the teaching institutions, they're the most enlightened and progressive. They are far ahead in seeing where the market is going. Mayo's reputation and its quality of care have always been superb. I don't see that changing."

MM

J. P. Miller is a free-lance writer residing in southern Minnesota and covering the greater Twin Cities area.

AUDIO-DIGEST. THE SHORTEST DISTANCE BETWEEN FOUR POINTS.



Everyone agrees that it's important to stay current. But with so many different priorities, who has the time?

Audio-Digest saves you the time and expense of traveling to meetings. Every year, we exhaustively cover more than 350 major meetings, seminars and postgraduate courses in 13 specialties. Then, because a 1-hour talk may contain only 30 minutes of true substance, we painstakingly edit so that you hear only the "meat" of the presentation—in less time, with no loss of important content.

Perhaps best of all, you stay current on **YOUR OWN TIME**. You listen when **YOU** want—at home, in the office between patients, while you're driving, while you're exercising. It's up to you.

For more information and a **FREE SAMPLE CASSETTE**, call **1-800-423-2308** now. And start closing the distance today.



Audio-Digest Foundation®

All medical courses are planned and produced in accordance with the Accreditation Council for Continuing Medical Education (ACCME) Essentials. Program tapes are presented by Audio-Digest Foundation, a subsidiary of the California Medical Association.

The California Medical Association is accredited by the ACCME to sponsor continuing medical education for physicians.

Each Audio-Digest program is approved for up to 2 hours of Category I credit, and may be applied toward the American Medical Association's Physician's Recognition Award and additional credit where designated by qualified boards and associations, including being acceptable for 96 hours annually of prescribed credit by the American Academy of Family Physicians.

0643

Talking to Your Patients About Gun Violence and Gun Safety

Physicians can help prevent death and injury from firearms by providing patients with practical advice.

Shari Hamilton

Editor's Note: It's true that guns don't kill people unless someone pulls the trigger. However, from 1979 through 1991, enough people pulled the trigger to kill 50,000 children and teenagers, about the total number of battle casualties during the Vietnam War. Teddy bears and toasters are more regulated than guns, according to the Minnesota Action Plan to End Gun Violence. The most significant health threat facing a 15-year-old in Minneapolis is violence, often from firearms.

Minnesota physicians are responsive to threats to the health of their patients, including public threats. The MMA House of Delegates at last year's Annual Meeting asked for information to help physicians respond to the threat that unsafe use and storage of firearms poses to our children. This month's Public Health Reports provide physicians with information regarding gun safety and teaching gun safety to their patients.

The first article, excerpted from a recent Wisconsin Medical Journal article, provides practical tips on educating your patients regarding gun safety in the home. The second article, written by a long-time DNR employee, is on hunting safety (page 25). Also this month, our Clinical & Health Affairs article discusses the incidence of nonfatal gunshot wounds in Minnesota and the need to establish a system for tracking gunshot wounds (page 29).

While new to many of us, teaching gun safety to parents and other adults, children, and teenagers can't be much more difficult than teaching safe sex (and abstinence) to teens.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

Children are alive with curiosity. But unlike the fabled cat tale, kids don't have nine lives. Children need firearm safety education before their curiosity leads them to investigate firearms and costs them their lives.

While adults sometimes deal with guns nonchalantly, paying little or no attention to the weapons because their presence is so commonplace, youth find guns a

source of fascination. Sometimes children are more aware of the location of guns and ammunition in the home than are their parents.

That message was pitched home to Richard G. Roberts, M.D., J.D., of Belleville, Wisconsin, last year when he had two young brothers in for elementary school physical exams.

Relates Roberts: "When I asked my usual safety questions ('Do you use seat belts? Wear a bike helmet?'), I also asked their mother: 'Do you have any guns in the home?' "

The woman replied that she thought her husband used to have a gun but that he got rid of it.

"The 7-year-old corrected his mother, as 7-year-olds love to do. 'No, Mom. Dad's gun is in the shoe box on the top shelf of his closet.'

"The 5-year-old brother piped up: 'And the bullets are in the middle drawer of his dresser.'

"Mom got all pale and sweaty," says Roberts, as she contemplated the grave ramifications of her sons' words.

The episode conjures up frightening images of real-life tragedy, like the incident that occurred February 13 in Stevens Point, Wisconsin. Nine-year-old Jack Lipowski died of a gunshot wound accidentally inflicted by his 11-year-old brother. The boys found a key and unlocked a drawer where their father kept a loaded gun. The 11-year-old, the news report said, removed the bullet clip from the gun, thought it was unloaded, pointed it at his brother while they were playing, and pulled the trigger, fatally wounding his younger brother in the head.

James Concannon, M.D., a Kenosha, Wisconsin, emergency physician, suggests educating patients by reviewing with them the risk of injury to self or children—in much the same way a physician would discuss with a mother of young children the temperature setting on her hot water heater.

"Guns are all over. The problem is here. Children are hurt all the time. Just pick up a newspaper or turn on the news," says Concannon, noting that news coverage understates the problem since media rarely report suicides or injuries related to depression.

Concannon says physicians need to stress to patients that guns are very destructive—more likely to be lethal than any other weapon. Suicide attempts by drug overdose, carbon monoxide, and self-mutilation are far less likely to be successful than suicide by gun.

“Doing something in the aftermath of a tragedy is ineffective. That’s why you have to be proactive,” he concludes. Concannon recommends that physicians interested in finding out more about talking to patients about gun violence should contact the Center for Handgun Violence (P.O. Box 425, Bladensburg, MD 20710-9974) and obtain an audiotape called “STOP—Steps to Prevent Firearm Injury.” (One side of the tape offers insights by former Surgeon General C. Everett Koop, M.D., and the other side provides examples of physician-patient conversations on gun safety.)

When questioning parents and children about gun safety, many doctors, like Roberts, have found it works best to slip in gun safety questions with inquiries on bike helmets and water safety, simply by inquiring, “Are there guns in the house?” If yes, Roberts follows up with questions about accessibility and information on gun locks and gun safes.

For adults without children, Roberts uses a slightly different tact, asking men about personal safety habits—whether they wear seat belts, drink alcohol and drive, or keep guns at home.

For women, the Belleville family physician begins by asking about arguments and conflict resolution. “Everyone argues. Are you ever afraid for your safety (when you and your spouse argue)? What do you fear happening? Are there guns at home?”

Susan Torhorst, M.D., of Madison, Wisconsin, says she asks gun safety questions during patient physicals, but she says this is difficult during shorter office visits. The family physician says the response she has received to her inquiries about guns has been very positive, with most patients eagerly sharing their methods of securing their guns.

Torhorst is concerned by her finding that some women are aware guns are in the home but have no idea where the firearms are kept. In those cases, Torhorst suggests they find out where the weapons are and determine whether they are properly secured.

Bernie Micke, M.D., a physician in Madison, Wisconsin, says he encourages physicians who are not yet talking about gun safety to include those questions with inquiries about alcohol, smoking, and seat belts. He says that while his questions about guns have met with mixed responses, people are rarely offended. “Some people have strong feelings on the subject, while others are willing to look at different alternatives,” Micke says, adding that either way, he doesn’t feel his questions threaten the physician-patient relationship.

When his patients report guns are present in their homes, Micke suggests that they consider whether a gun is actually needed. He stresses to his patients that guns are more likely to be used for suicide than to protect them from criminals. He also reminds his patients that firearms are frequently stolen and if not secured properly,

their gun might one day be used to commit a crime. (According to the Bureau of Alcohol, Tobacco and Firearms, each year between 200,000 and 250,000 guns are stolen from U.S. homes.)

Micke says he has begun suggesting that parents inquire about gun security at the homes where their children play. It doesn’t do much good to lock up all your guns at home and then send your children off to play in

Physician Guidelines for Talking About Gun Safety

By Murray L. Katcher, M.D., Ph.D.

Keep the message simple

- A gun is the most dangerous product in the home.
- Guns and ammunition should be made inaccessible (especially to minors).
- If you keep a gun, empty it out and lock it up.

Say it with style

- Be nonjudgmental.
- Avoid political controversy; keep it a health issue.
- Be a good listener and a good adviser. Respond with sensitivity.

Murray Katcher is a pediatrician at the University of Wisconsin in Madison. Excerpted with permission from the Wisconsin Medical Journal, February 1995. © 1995 State Medical Society of Wisconsin.

Firearm Safety Tips for Physicians and Their Patients

Physicians should encourage all firearm owners to take a certified firearm safety class. In addition, physicians can suggest the following guidelines:

- Make sure firearms in the home are free of ammunition and locked up; store firearms and ammunition separately.
- Use trigger locks, barrel locks, or cylinder locks.
- Never throw away ammunition in the trash.
- Never store a firearm on a bedside table or under a mattress or pillow.
- To help prevent firearm theft, do not store firearms among valuables, such as jewelry or silver.
- Families with a depressed family member or children at home may choose not to store a firearm or ammunition in the house at all. If a firearm is stored in the home, make sure it is in a locked case and that a responsible party carries the key at all times.

National Violence Prevention Programs and Organizations

ABA Legal Solutions to Gun Violence Project
American Bar Association
1800 M Street NW, 2nd Floor South
Washington, DC 20036-5886
Bruce Nicholson, 202/331-2685

Coalition to Stop Gun Violence
100 Maryland Avenue NE
Washington, DC 20002
202/544-7190

Handgun Epidemic Lowering Plan (HELP) Network
(Provides resources on firearm violence prevention)
2300 Children's Plaza, #88
Chicago, IL 60614
312/880-3826

National Center for Injury Prevention and Control
(Youth violence prevention demonstration programs)
Centers for Disease Control and Prevention
Mail Stop MSK60
4770 Buford Highway
Atlanta, GA 30341
Timothy Thornton, public health adviser
404/488-4646

National Crime Prevention Council
1700 K Street NW
Washington, DC 20006
Attention Faye S. Warren
202/466-6272, ext. 126

Steps to Prevent Firearm Injury (STOP)
(A partnership program between the American
Academy of Pediatrics and the Center to Prevent
Handgun Violence)
Center to Prevent Handgun Violence
1225 Eye Street NW, Suite 1100
Washington, DC 20005
Ricky O'Kane, health education coordinator
202/289-7319

Straight Talk About Risks (STAR) Program
Education Division
Center to Prevent Handgun Violence
1225 Eye Street NW, Suite 1100
Washington, DC 20005
Nancy Gannon, division director
202/289-7319

a house where gun safety is not respected. Most parents are taken off guard when that question is raised, says Micke. It's a safety question they just haven't considered.

Many physicians have compared the process of learning to talk to patients about gun safety to that of learning to ask about seat belt use, alcohol consumption, domestic abuse, and other health risks. In the beginning, some physicians had to write reminder notes about discussing those issues. But in a short time, the questions became more automatic, and they found conversations about those issues just as easy as talking about other health topics.

In addition to discussing gun safety during patient consultations, physicians have found many other ways to get their message across. Some have started public health campaigns with billboards and brochures. Some individual physicians have talked to civic clubs. Several La Crosse physicians took their gun safety message to the La Crosse mall, moving among the crowd to talk about

this important issue with shoppers. Working through the school system, Dane County, Wisconsin, physicians sent letters on gun safety home to parents. Chippewa Falls is providing its gun safety officer with public health materials for the next three years. And a physician in Park Falls, Wisconsin, spearheaded an effort that included giving out 150 trigger locks.

The methods are as limitless as your imagination. You will never know how many lives you may have saved or how many kids you have kept from being injured. The success rate is immeasurable. But you will know how many lives you won't influence, how many kids you won't save if you don't try.

MM

Shari Hamilton is editor of the Wisconsin Medical Journal.

Excerpted with permission from the Wisconsin Medical Journal, February 1995. © 1995 State Medical Society of Wisconsin.

COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
 Bloomington, MN 55437
 Local (612) 881-0618
 WATS (800) 328-6246
 FAX (612) 881-7297



C. F.
anderson
 COMPANY, INC.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
 Physician Placement Dept.
 Fairview Clinic Services
 600 West 98th Street, Suite 390
 Bloomington, MN 55420
 1-800-842-6469

The Health Center for Women

Internal Medicine and Family Practice Physicians

Looking for a practice that focuses on the care and issues of women? The Health Center for Women is a primary care clinic dedicated to offering respectful, patient-centered care to women from adolescence through geriatrics.

We are expanding and have full and part-time opportunities for board certified internal medicine and family practice physicians with expertise in women's health. These positions involve one evening clinic - some hospital attending is preferred, but not required.

Located at University Avenue and Hwy. 280 in St. Paul, our beautiful new facility offers state-of-the-art equipment, a top support team and a cohesive group of professionals. We also offer a competitive salary and benefits package. Please forward your CV to: **Sandy Lachman, Physician Services, Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. Or fax your CV to (612) 221-8571. EOE**

 **HealthPartners**
 Ramsey Clinic
 The Health Center for Women

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Jonathan Cohen, M.D., MPH
Director, Urgent Care/Emergency Department (1110)
Veterans Affairs Medical Center
One Veterans Drive
Minneapolis, MN 55417
612-725-2158



An equal
opportunity
employer.

STATE FARM INSURANCE COMPANIES

Is seeking a Regional Medical Director who will act as the medical consultant for the North Central Region. This is a great opportunity for a physician who is interested in occupational health as well as working with employees and management on a professional and ethical basis. There are currently 1200 employees in the Twin Cities metro area and 500 employees located outstate.

There must be a willingness to commit a limited number of hours on a weekly basis for the following:

At the Regional Office location:

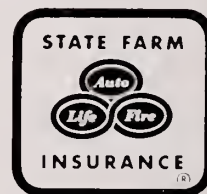
- Review of pre-employment health questionnaires
- Provide input and opinions on employee medical issues

At the physician's office location:

- Conduct middle management and periodic physicals for eligible employees

This position offers flexibility and a very good compensation structure. If you are interested in additional details, please contact Susan Peltan, Regional Personnel Manager, at (612) 631-4241, or send inquiries to State Farm Insurance Companies, 1500 West Highway 36, St. Paul, MN 55161.

Note: We will be moving to our new Woodbury, Minnesota, location in the Fall of 1996.



CONTINUING MEDICAL EDUCATION

ST. PAUL-RAMSEY MEDICAL CENTER

Mark your calendar now for these upcoming conferences:

FALL-SPRING CONFERENCE SCHEDULE

1995

- | | |
|----------------|--|
| October 5-6 | Infection Control in Long Term Care Facilities-Part I, St. Paul
(Part II is December 11-12) |
| October 21 | Justification of Aquatic Therapy: Functional Outcomes,
Clinical Research and Public Awareness, St. Paul |
| November 9-10 | Changing General Surgical Practices-1995, St. Paul |
| November 16-18 | Strategies in Primary Care Medicine, St. Paul |
| December 7-8 | Cardiopulmonary Medicine, St. Paul |

1996

- | | |
|----------------|--|
| February 22-23 | Burn Care Today, St. Paul |
| March 7-8 | Family Medicine Today, St. Paul |
| March 28-29 | Critical Care 1996, St. Paul |
| April 12 | ENT Update for Primary Care Physicians, St. Paul |
| April 18-19 | Ob/Gyn Update 1996, St. Paul |

INFORMATION AND
REGISTRATION:

*Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992, Fax 612/292-4773*

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

Safe Hunting

Respect, responsibility, and regiment are crucial to firearm safety when hunting, says this DNR conservation officer, who offers thoughts and tips that physicians can share with patients who hunt.

Harris Mills

Like so many of us who grew up in rural Minnesota, I cannot say when I first witnessed the power of a gun and the finality of the death it so easily caused. Was it the time Dad shot the pocket gophers? Was it when the raccoons raided the sweet corn? This I can say for sure: I knew what a gun could do long before I got a toy gun. And I learned, as did all my little friends, that we were not allowed to handle a real gun until we were older.

My father knew that owning and using a firearm requires a great deal of personal responsibility and training. Unfortunately, the number of hunting accidents each year is strong evidence that many people are not following the established rules for the safe and responsible handling of firearms. In Minnesota in 1994, there were 37 hunting accidents, four of them fatal. On average, 40 firearm-related accidents and five fatalities occurred during each of the last five years in this state. When a hunting accident occurs, only two explanations are possible: either someone did not know or understand the rules, or someone failed to follow the rules. Below are some thoughts on promoting safe hunting and firearm handling.

AVOID HUNTING COMPETITIVELY

Since most accidents occur because an individual breaks a rule, it is helpful to understand why and under what circumstances a person is prompted to ignore a safety rule. Hunting is too often thought of as a competition, which encourages risk-taking. In a recent firearms safety course, the instructor prodded the students to consider the *real* reasons a safety rule might be ignored—reasons that go beyond such responses as “in a hurry,” or “don’t want to miss the shot.” When hunting is competitive, the students admitted, there’s pressure to try to “be successful,” to “prove yourself” or to shoot the “first, biggest, or most game.”

We must help hunters understand how inappropriate and dangerous it is to think of hunting solely in terms of success or failure in shooting game. If we imply that shooting game is the essence of hunting, then the message

to our children is that the ends justify the means, even if it means taking unnecessary risks. When children, or beginners, have had the opportunity to discuss and think through a situation before they experience it, instead of having to react spontaneously as it happens, they will be more likely to follow the rule.

To increase safety, hunting should be thought of as a rite or ritual, not a competition. A rite is a ceremonial or solemn act with proscribed rules or customs. Considering hunting a solemn act affirms the central importance of behaving in a way that demonstrates respect—respect for self and the safety of others, respect for the opinions and the property of others, respect for the environment, and respect for the animal being hunted. Following rules eliminates unnecessary risk.

DETERMINE WHO’S CAPABLE OF HANDLING FIREARMS

An obvious step in preventing firearm accidents is to acknowledge that many people simply are not capable of safely handling a firearm. They may not have the personal qualities, the training, or either. A good summary of the qualities or characteristics a person needs to safely handle a firearm is given by Clem Lehrer of Big Fork, Minnesota, a volunteer firearms instructor since 1956. “I teach what I call the three R’s of firearm safety: respect, responsibility, and regiment,” says Lehrer. According to Webster’s, respect means to show consideration for something. Responsibility means able to distinguish between right and wrong, to think and act rationally, and to be accountable for one’s behavior. Regiment means to organize and subject to strict discipline and control.

It’s true that a 10-year-old child may have these qualities and, with proper training, could safely handle a firearm. It’s also true a 35-year-old with knowledge and training in firearms may not have these qualities. More important, children can develop these qualities by hunting under the close supervision and guidance of a caring, experienced adult.

LIMIT ACCESS TO FIREARMS

People who are incapable of safely handling a firearm should not have access to one. Even under lock and key, a firearm in a household where a family member or a frequent visitor is addicted to alcohol or drugs, is violent, or is mentally ill, is a high—and unnecessary—risk. There often are legal means available to remove the firearm. For assistance, call the city or county attorney's

office or the local law enforcement agency. Other options might include selling the gun to a dealer, asking a gunsmith to remove the firing pin so the gun is incapable of firing, or having a responsible friend or relative store the firearm.

Some part of the firing mechanism should be removed or altered on any firearm displayed as an antique, a keepsake, or souvenir. This can be done by a gunsmith

Hunting Safety Tips

Plan the hunt to eliminate risk

A safe hunt requires more than a basic knowledge of firearms. The hunt itself needs to be planned in a way that eliminates risk. Beginners, especially, need careful guidance and direction from experienced hunters.

- Scout the area you plan to hunt. Be certain everyone knows the location of buildings, roads, and other places people may be. Discuss what is meant by the rule, "Be sure of your target and what is beyond." Explain why shooting in the direction of a road or over a hilltop is especially dangerous.

- Be certain each hunter knows the safe zone of fire. Caution beginners that when there is any movement or sound, their first thought should be that it's another person. Explain that a hunter wearing blaze orange can walk through a cedar swamp, a pine plantation, or a corn field and not be visible at all.

- Agree that everyone will load only when in position and sure of the safe zone of fire.

- Remind one another to keep the safety on and the finger outside the trigger guard until after the hunter has shouldered the firearm and it still looks safe to shoot.

- Finally, make sure everyone understands that there's a lot more to being a good hunter than shooting game. A good hunter knows how to avoid the risk of an accident.

Safely load and unload firearms

Loading and unloading firearms at the proper time and place can greatly reduce the risk of accidents. Keeping the muzzle pointed in a safe direction is the rule, but in so many situations, just having the gun loaded is an unnecessary risk. All it takes is a movement, a slip, or a fall, and a loaded gun is pointed at someone.

Hunters should set rules for themselves when loading and unloading:

- Load when in position—actually in the woods, in the blind, or stand. Do not load in camp, near buildings or parking areas, or when in group.

- Load only when you know your zone of fire, that

is, the direction you can safely shoot.

- Load only when there is no danger of slipping, falling, or dropping the firearm.

- Unload whenever you are unable to give your full attention to controlling the firearm.

- Unload before:

- setting the firearm down;
- exiting a tree stand;
- approaching landowners, hikers, or other hunters;
- retrieving or carrying game;
- crossing slippery or rough terrain;
- returning to camp, the parking area, or the highway.

These basic rules of safety aren't covered by law and regulation—all the more reason why hunters need to plan ahead and decide for themselves rules for the hunt.

Keep warm to avoid accidents

Cold weather is very much a factor in the state's hunting accidents. If we look at the way we hunt, our attitudes toward the cold, and the effect the cold has on our ability to think and move, it's easy to see the connection.

Minnesotans learn to tolerate the cold. We shiver, stiffen up, and sometimes lose the sense of touch in our fingers and toes. Minnesota hunters may assume this is normal for opening day. What many hunters fail to consider, however, is that as the body cools down, we not only begin to lose our sense of balance, we also start losing our ability to think clearly. The risk of dropping the gun or falling increases. Our judgment begins to fail. We may even forget to keep the muzzle pointed in a safe direction.

That's the scary part. We actually lose our ability to concentrate on what we're doing. Too long in the cold and a hunter can end up both clumsy and careless.

The problem is not limited to below-freezing temperatures, either. In fact, getting wet on a windy day in 50-degree weather can be even more dangerous.

The ability to resist the cold is different for each

without any permanent or noticeable change in the appearance of the firearm.

Finally, the basics: Keep all guns unloaded and under lock and key. Keep ammunition under lock and key. Carefully control who has access to the key.

Steel gun safes sell for less than \$200 at discount stores. If that's too expensive, padlocks or bike lock cables can be used to lock open the action of the gun to

person. A key symptom to watch for is severe shivering. That's a signal to get warm and dry immediately.

Be especially cautious with old lever action rifles

Anyone using an old lever action rifle must know the several ways the gun can accidentally discharge:

- **When chambering:** To chamber a round in a lever action, the lever is moved forward, and then back. The movement of the lever also cocks the hammer. As the lever is moved, the trigger is fully exposed. If the trigger is hit as the lever is moved back, the gun will fire!

- **When placing the hammer at half-cock:** A round has been chambered and the hammer is fully cocked. Unless the gun is fired or unloaded immediately, the hammer should be placed in the half-cock or safe position. To do this, the hammer is held in place with the thumb, the trigger is pulled, and then the hammer is slowly lowered. If the hammer should slip from the thumb as the trigger is pulled, the gun will fire! The risk of an accidental discharge is greater with cold fingers and bulky gloves.

- **If the hammer is hit or struck:** The hammer on a lever action rifle is designed so that it can be easily cocked. Because of this design, it is also easy to bump or hit the hammer.

Be aware that a sharp blow to the hammer of a lever action rifle can cause the gun to fire, even when the hammer is in the half-cock or safe position.

- **When unloading:** The first example explained how an accidental discharge can occur when chambering a round. The same thing can happen when unloading the gun. That's because the tube magazine can be emptied only by chambering and ejecting each round.

Again, each time the lever is moved forward and brought back, the hammer is cocked and the trigger is exposed. If the trigger is hit by the thumb, for instance, the gun will fire! Newer models of the lever action rifles have a safety that can substantially reduce the risk of an accidental discharge.

Firearm Safety Education: Resource List

- The NRA's "Eddy Eagle Program" received the American Safety Council's highest award in 1994. The program uses Eddy Eagle as a mascot in coloring books, workbooks, and an animated video to teach children kindergarten through the sixth grade the following message: *If you find a gun, stop. Don't touch. Leave the area. Tell an adult.* For further information, call the National Rifle Association, 800/672-3888.

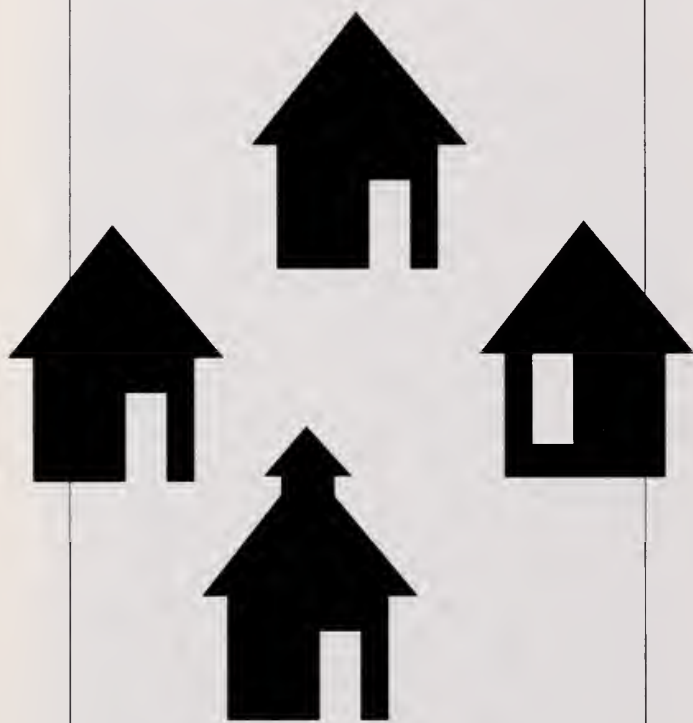
- The 4-H Shooting Sports Program offers a progression of eight shooting disciplines for youth ages 8 to 19 years old and includes a 15-hour course on wildlife. Eight-year-olds begin learning safety and target shooting with air rifles and bows and arrows. Adults are encouraged to help and to learn along with the children. Adults can become trainers by attending a training session. Persons interested in 4-H shooting sports are invited to call the Minnesota Extension Service in the county where they reside.

- Persons born after December 31, 1979, must satisfactorily complete a Minnesota Firearm Safety Training course before they can purchase a Minnesota hunting license. Youth may enroll at age 11 but will not receive certification until age 12. Adults are encouraged to attend the course to help their kids, as well as to learn themselves. Certification allows youth age 12 to purchase a big game license, serves in lieu of a small game license for youth ages 13, 14, and 15, and allows youth age 14 and older to hunt without an adult. The course is a minimum of 12 hours and includes field training exercises and firing on a range. The course covers the basics of safe gun handling, hunting safety and responsibility, wildlife identification, and outdoor survival. Classes are taught throughout the state by volunteer instructors certified by the Minnesota Department of Natural Resources. Anyone interested in enrolling in classes or becoming a volunteer instructor is encouraged to call their local conservation officer, or call Ron Deppa or Diane Carlson at the Minnesota Department of Natural Resources, Division of Enforcement, 800/366-8917.

- Gun clubs and ranges are found in communities throughout Minnesota. Club members are often affiliated with the National Rifle Association, and many have NRA-certified instructors qualified to offer training on handguns, rifles, and shotguns. For further information on area gun clubs or NRA training, check with local gun dealers or contact the NRA at 800/672-3888.

Children on ventilators...

When young people need this complex form of care, there's a place with experience and successful outcomes.



Since 1988, we have provided comprehensive inpatient and outpatient medical, rehabilitative and habilitative care to infants, children and adolescents who require a ventilator or have an airway obstruction. Medical conditions include:

- spinal muscle atrophy
- muscular dystrophy or polio
- spinal cord injury or anomaly
- central breathing dysfunction
- premature infants with bronchial-pulmonary dysplasia or chronic lung disease

Our goal is to return these young people to their home and community.

To refer a patient to the TDR program, or for a copy of a 10-minute educational video, call (612) 229-3954.

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

prevent it from firing. Gun dealers and gunsmiths can offer further advice on how to secure a firearm so that it cannot be fired.

SIGN UP FOR GUN SAFETY COURSES

Today, the best advice for parents is to enroll their children in gun safety classes and attend those classes with them so that they also learn and can reinforce the lessons taught (see resource list, page 27). However, merely reciting rules learned in class falls short of understanding the finality of death and learning how to react in real-life situations. In addition to training, young hunters need practice and repetition under the guidance of adult supervision. Inexperienced hunters may have difficulty applying basic skills in a variety of complex situations, and parents can help them fine tune the skills learned in class.

CONCLUSION

Children who learn to respect hunting as a ritual and to follow the prescribed rules and customs will come to recognize the power of a firearm, the finality of death, the dependency of humans upon nature, and what is real and what is make-believe. Through the ritual of hunting, a child can learn to become an adult. MM

Harris Mills has been a conservation officer for 25 years. He and his family live in Grand Rapids, Minnesota.

© 1995 Minnesota Department of Natural Resources.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



Central Minnesota
Group Health Plan

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

The Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota

Gary Riestenberg, M.S., and Douglas D. Brunette, M.D.

ABSTRACT

We surveyed a sample of Minnesota hospitals to identify the known incidence of nonfatal gunshot wounds (NF-GSW). Only 12 of the 25 hospitals surveyed used E-codes and were able to retrieve NF-GSW data. Only five hospitals had data dating back to 1991. Ninety-two percent of all known NF-GSW (1,425) occurring in Minnesota from 1991 to 1994 were recorded at the three Level 1 Trauma Centers located in the Twin Cities of Minneapolis and St Paul. The incidence of NF-GSW patients admitted to these three trauma centers has increased 20% from 1991 to 1994. Sixty percent of the NF-GSW treated in Minneapolis involved residents living in four zip code areas, comprising 30% of the city's population. Recommendations for improved NF-GSW data collection and likely impact on prevention are reviewed.

Numerous recent studies have identified a lack of reliable data on nonfatal gunshot wounds (NF-GSW).¹⁻⁴ A review of the hospital discharge records at Hennepin County Medical Center indicated the number of patients admitted for gunshot wounds (GSW) rose from 71 in 1982 to 165 in 1992, an increase of 132%.⁵ In contrast, previous research of Minnesota's death certificates found no appreciable increase in the state's annual fatal gunshot wounds (F-GSW), which have been hovering above 300 (339 in 1993) for the past decade.⁶ This apparent discrepancy in trends suggests that better data on NF-GSW prevalence rates (GSW/100,000 population) are needed in Minnesota. To assess prevalence rates accurately, Minnesota needs an integrated system to track all GSW. Our study found that many hospitals have no system for tracking NF-GSW, and the state has no comprehensive system.

Growing evidence shows that the incidence of GSW is highly localized; the vast majority of GSW occur in geographically concentrated areas and among specific population groups.⁷ An integrated tracking system would verify this and would allow the state to better target corrective and preventive resources. Our data—provided primarily by three metro-area trauma centers—show that NF-GSW occur primarily among certain age and gender groups and within certain geographic areas.

The purpose of this study is to investigate the incidence and locale of NF-GSW in Minnesota and calculate corresponding prevalence rates of NF-GSW. We make recommendations for setting up a statewide tracking system for GSW data.

BACKGROUND

A telephone survey of officials from the Department of Health, Department of Public Safety, and several local police and sheriffs' departments provided the following background information regarding Minnesota gunshot wound data. Currently, three sources report GSW data in Minnesota: the county coroner, the police, and medical personnel. The county coroner submits death certificates to the Minnesota Department of Health, which publishes these data in the annual "Vital and Health Statistics Report." This report contains Minnesota resident-only data and includes F-GSW of all types as described by the International Code of Diseases (ICD-9). These include E922 unintentional, E955 suicide, E965 assault/homicide, E970 legal intervention, and E985 undetermined.⁸ A fourth code digit identifies the type of firearm involved (handgun, shotgun, rifle, military gun, undetermined). Minnesota's 1993 prevalence rate for F-GSW is 7.5/100,000 population (339 fatal gunshot wounds).

Concurrently, the Minnesota Department of Public Safety tracks F-GSW that are a result of crimes, as well as gun-related aggravated assaults. These data are annually reported in the "Minnesota Crime Information Report"⁹ and include non-Minnesota residents who were victims of NF-GSW while in Minnesota. The data are submitted by the local police via the Criminal Justice Information System. In 1993, Minnesota reported 2,077 gun-related aggravated assaults (includes actual and threat of assault), a rate of 46/100,000.¹⁰

Medical personnel who treat firearm injuries are mandated by Minnesota Statute (626.52 to 626.555,

"Reporting of Suspicious Wounds,") NF-GSW, as well as all violence-related sharp instrument wounds and blunt assault wounds. Unfortunately, police data are filed by type of

incident and are not cross-coded by type of injury. NF-GSW data are not readily accessible from this source.

With no state or government agency tracking NF-GSW data,* the primary remaining sources are hospital discharge records from trauma centers and emergency departments. The availability of these data depends upon the injury coding procedures of each hospital.

METHODS

We obtained a list of Minnesota hospitals providing emergency department (ED) services from the Department of Health.¹¹ We surveyed by telephone the 25 hospitals with at least 16,000 annual ED visits. These included three Twin Cities metro trauma centers, seven suburban hospital emergency departments, seven Twin Cities metro emergency departments, and eight outstate emergency departments. After briefly describing the nature and purpose of the study, we inquired about the availability of NF-GSW data. Hospitals with coded data provided hard copy printouts. Data included incidence, E-code, victim's sex, age (in 10-year increments), and zip code of residence. The incidence per zip code allowed calculations of localized GSW prevalence rates.

RESULTS

At the time of the survey, only 12 of the 25 hospitals surveyed used formal coding procedures to identify distinct GSW data. Most of these had only recently begun to code. Only five hospitals had data dating back to 1991. Ninety-two percent of all known NF-GSW (1,425) occurring in Minnesota from 1991 to 1994 were recorded at the three Level 1 Trauma Centers located in the Twin Cities metro area (Hennepin County Medical Center, St. Paul-Ramsey Medical Center, and North Memorial Medical Center). Seventy-eight percent of the known NF-GSW vic-

*The Minnesota Department of Natural Resources publishes a detailed record of reported sport hunting fatal and nonfatal firearm injuries within the state. During 1993 there were five F-GSW and 32 NF-GSW.

Table 1

Known nonfatal gunshot wounds treated in three Twin Cities metro hospitals

	1991	1992	1993	1994	Total
Combined three Twin Cities metro trauma inpatient GSW	245	264	291	308	1,108
One Twin Cities metro outpatient GSW	—	40	100	62	202
Total Twin Cities metro nonfatal GSW	245	304	391	370	1,310
Total Minnesota fatal GSW*	350	349	339	—	—
Total fatal and nonfatal GSW	595	653	730	—	—

*Minnesota Center for Health Statistics. Minnesota resident death by sex and age by single cause of death, 1991-1993. [Unpublished tables]. Minneapolis: Minnesota Department of Health.

Table 2

Comparison of ICD-9 external cause of nonfatal gunshot wounds from three Twin Cities metro hospitals and ICD-9 E-codes of Minnesota statewide fatal gunshot wounds

	Nonfatal (inpatient only)		Fatal*	
	'91-93 avg.	Percent	'91-93 avg.	Percent
Accident E-922	91	11.4	38	3.7
Suicide E-955	67	8.4	767	74.0
Assault E-965	581	72.6	218	21.0
Legal intervention E-970	11	1.4	0	0
Undetermined E-985	50	6.2	14	1.3
Total	800	100.0	1,037	100.0

*Minnesota Center for Health Statistics. Minnesota resident death by sex and age by single cause of death, 1991-1993. [Unpublished tables]. Minneapolis: Minnesota Department of Health.

tims were treated as inpatients; however, only one Twin Cities metro trauma center could provide outpatient GSW data, i.e., additional GSW patients treated by the hospital's ED. These data vary considerably over the three years, but the overall average for this hospital was 33% of inpatient GSW. Only one of the seven non-trauma center Twin Cities metro hospitals with ED services used GSW codes; that hospital logged seven GSW during 1993. Of the seven Twin Cities suburban-area hospitals offering ED services, only three had distinct GSW data; they reported from three to nine GSW/year.

Of the eight outstate hospitals surveyed, only two had three years of data, and three had just one year of data. There was an overall average of eight GSW/year among this group of hospitals. The state's 115 smaller suburban and outstate hospitals with ED services were not included in the survey.

NF-GSW INCIDENCE

The incidence of NF-GSW inpatients admitted to the three Twin Cities trauma centers has increased 20% from 1991 to 1994, while the statewide incidence of F-GSW has decreased 3% from 1991 to 1993 (1994 F-GSW data are not yet available).

The known NF-GSW coded by the three Twin Cities metro trauma centers nearly doubles the previously known incidence of GSW in Minnesota (see Table 1). Data on the statewide incidence of NF-GSW are not available.

For the period studied, 87% of NF-GSW victims were male and 13% female. One percent were age 0 to 10, 40% age 11 to 20, 35% age 21 to 30, 18% age 31 to 40, and 7% over age 40.

A comparison of F-GSW and NF-GSW by type of GSW shows nearly as many individuals used a firearm to commit suicide as to assault someone else (see Table 2). Seventy-four percent of F-GSW were self-inflicted, while 72% of NF-GSW were the result of assaults by others. There were 186 (24%) more GSW suicides than GSW assaults. Unsuccessful suicide attempts accounted for 8.4% of NF-GSW.

CALCULATING GSW PREVALENCE

In Minneapolis, 60% of the 314 known GSW pa-

tients were residents of four zip code areas during 1994. These four zip codes contained 114,000 residents, comprising 31% of the Minneapolis city population. Likewise, during 1994 in St. Paul, 60% of the 56 known GSW patients were residents of four zip code areas; however, these 124,000 residents comprise 46% of the city's population. Tables 3 and 4

Table 3

Prevalence rates for 1994 Minneapolis high-injury zip codes

Zip	Population*	# GSW†	GSW/ 100,000
55404	19,903	46	231.1
55407	34,059	36	105.8
55408	29,658	27	91.2
55411	30,088	78	263.3
Mpls— All zips	368,000	212	57.6

*The sourcebook of zip code demographics. 8th ed. Arlington, Virginia: CACI Marketing Systems, 1993.

†Hospital only data. Does not include Vital Statistics data, e.g., suicides, DOA.

Table 4

1993 census demographics of Minneapolis high-injury zip code areas*

Zip	Number injuries	Household size	Percent racial mix				Household income			
			White	Black	Asian	Hispanic	<\$15k	Median (thousands)	Per/capita (thousands)	Below poverty
55404	46	1.89	55	24	7	4.5	48.3%	\$15.4	\$10.4	33.5%
55407	36	2.47	63	22	5	3.3	25.3%	\$25.7	\$12.9	16.7%
55408	27	1.93	68	21	6	3.6	30.1%	\$22.9	\$15.7	18.6%
55411	78	2.82	38	49	8	3.0	38.4%	\$20.5	\$9.7	31.2%
Minnesota overall overage census demographics		2.55	94	2.4	2.2	1.5	19.0%	\$34.2	\$16.2	10.5%

*The sourcebook of zip code demographics. 8th ed. Arlington, Virginia: CACI Marketing Systems, 1993.

Table 5

International handgun-only fatal gunshot wound rates for 1990

	F-GSW	Population (millions)	Rate/100,000
USA*	10,567	249	4.2
Japan	87	124	0.07
Great Britain	22	54	0.04
Canada	68	27	0.25
Sweden	13	9	0.14
Switzerland	91	7	1.4
Australia	10	18	0.06

*U.S. Department of Justice, Federal Bureau of Investigation. Uniform crime reports: crime in the United States: FBI Uniform Crime Program. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1991.

Additional GSW data courtesy of Handgun Control, Inc., a Washington, D.C., gun-control lobby, which canvasses the above countries' embassies for gunshot wound data. Population figures from "1994 Statistical Abstract."

show the prevalence rates and demographics of the high-injury zip code areas of Minneapolis.

Zip code 55411 has more than double the incidence of GSW and nearly double the rate per 100,000 population as compared with the average for the other three high-injury zip code areas of Minneapolis. Zip code 55411 also has nearly double the number of African-Americans (49%), the lowest per-capita income (\$9,700), and the second-highest percentage of households that fall below the poverty level as compared with the other high-injury areas. When compared with Minnesota's overall demographics, these four zip codes are very low-income areas and have a mixed racial makeup. It is possible, however, that many of the factors determining GSW are not recorded as part of the U.S. Census demographics, e.g., gang membership, number of guns per household, and

participation in underground economies.

DISCUSSION

Perhaps the most notable aspect of firearm injury is the variation in prevalence rates (injuries per 100,000 population) for certain population groups and geographic areas. Table 5, for example, shows the wide variations in the rate of handgun-only F-GSW among several countries.

In the United States from 1979 to 1987, Alaska and Nevada had the highest annual state average rates of F-GSW at 26.4/100,000 population and 25.1/100,000, respectively. Massachusetts had the lowest at 4.6. Minnesota ranked fifth lowest with 7.¹² A 1994 study of GSW in New York City showed the homicide rate for males aged 15 to 24 was 247 for African-Americans, 157 for Latinos, and 16 for whites.¹³ A 1995 re-

view of 51 homicides in Minneapolis indicated that all occurred within 39 (32%) of the city's 122 census tracts.⁷ These data show that GSW can be a highly localized phenomena by either geographic area or by population groups. Our results revealed a geographic concentration of GSW in selected areas of the Twin Cities.

STUDY LIMITATIONS

Although the incidence of patients suffering from GSW in the Twin Cities metro area is clearly on the rise, the overall paucity of NF-GSW data limits our ability to develop a Twin Cities metro-area or statewide analysis of GSW. Only one Twin Cities metro hospital could provide ED outpatient GSW data, and 1994 was the only year for which all major Twin Cities metro hospitals were able to provide zip code data.

Previous researchers have suggested identifying a ratio of F-GSW to NF-GSW.^{2,4,14} Estimates for this

ratio range from 1-to-2+ to 1-to-7. While sufficient data are not available to calculate a fatal-to-nonfatal GSW ratio for Minnesota, we do know that in 1993, a 1-to-6 ratio describes the number of F-GSW compared with the number of gun-related aggravated assaults (threats of and actual assault) in Minnesota (339-to-2,077).^{9,15} Comparing the statewide F-GSW with the primarily Twin Cities metro NF-GSW data available from this study gives a ratio of nearly 1-to-1. Based on the paucity of NF-GSW reported from out-state Minnesota hospitals, the statewide ratio is likely about 1-to-2. Correspondingly, the inclusion of NF-GSW data would likely increase Minnesota's GSW prevalence rate from the current 7.5 (fatal only) to about 20 to 23 per 100,000 population.

RECOMMENDATIONS

Teret et al. have suggested that a firearm fatality reporting system be developed and patterned after the Fatal Accident Reporting System (FARS) as maintained by the National Highway Traffic Safety Administration.¹⁶ FARS collects uniform data from the states and reports on up to 90 different data elements characterizing each fatal crash and the vehicles and people involved. The national annual budget for FARS is only \$3.5 million.

Teret suggests that the following GSW data be collected:

- type, make, model, caliber, and serial number of gun involved;
- type of death/injury—suicide, homicide, accident, undetermined, or legal intervention;
- victim and shooter age, sex, drug/alcohol involvement;
- circumstances—date, time, type of location, other crimes;
- involvement of emergency medical services or samaritan assistance.

Both Wisconsin and Massachusetts have implemented a statewide hospital ED surveillance system similar to Teret's proposal for collecting weapon-related fatal and nonfatal injuries data.^{17,18} During the first six

GUNSHOT WOUNDS
continued on page 59

ANNOUNCEMENTS

• • • • •

MMA OFFICERS NOMINATED FOR 1995-96

The MMA Board of Trustees has accepted the following slate of nominees:

1995-96 MMA Officers

President-elect: Raymond G. Christensen, M.D.
Vice-President:
Paul R. Hamann, M.D.
Secretary: Leslie M. Rainwater, M.D., Judith F. Shank, M.D.
Treasurer: Erick Reeber, M.D.
Speaker of the House: Anthony C. Jaspers, M.D.
Vice Speaker of the House:
Blanton Bessinger, M.D.

AMA Delegation

Delegates:
A. Stuart Hanson, M.D.*
Ben P. Owens, M.D.*
Andrew J.K. Smith, M.D.
Alternate Delegates:
Kenneth W. Crabb, M.D.
Lyle Munneke, M.D.*
John M. Van Etta, M.D.
Bruce A. Norback, M.D.*
Thomas L. Peyla, M.D.*
*Current delegation members eligible for re-election.

Minnesota Physicians Foundation Board of Directors

Lea R. Hogan, M.D., East Metro
Thomas A. Stolee, M.D., Northeast
Gerald C. Peterson, M.D., Southeast
Elton G. Wing, M.D., Southwest
Lawrence M. Poston, M.D., West Metro

Nominations will remain open through the first session of the House of Delegates at the MMA Annual Meeting.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Objects To Sexual Misconduct Report

The Minnesota Medical Association has raised serious concerns about a report to the Minnesota Board of Medical Practice that recommends 24 sweeping legislative and policy changes in the way the BMP manages sexual misconduct cases. The report, "Recommendations to State Medical Boards for Improving the Management of Physician Sexual Misconduct Cases: Empowerment of Victims," was developed by the Consultation Group on Physician Sexual Misconduct, at a two-day meeting in May, but not released until July 8, two weeks before public hearings in Mankato, the Twin Cities, and Duluth.

Testifying at the hearings, the MMA raised objections to several of the report's recommendations, including the following:

- Eliminate confidentiality in contested case hearings when sexual misconduct is alleged. (A contested case hearing takes place only if a physician rejects the disciplinary sanctions recommended by the BMP medical complaint review committee and requests a hearing before an administrative law judge.)

- Share confidential data gathered during BMP investigations with criminal enforcement agencies.

- Discipline physicians for minor boundary violations, which are usually failures in communication. Disciplinary actions can be published in the newspapers.

The MMA also asked for clarification of a recommendation that the BMP revoke a physician's license if sexual misconduct is proved. A law

passed last year would automatically revoke a physician's license for a felony-level sexual conviction. It is not clear whether the report intends that a physician should lose his or her license for *any* level of violation, including a casual touch that was intended to comfort but was perceived as sexual.

Anthony C. Jaspers, M.D., testified for the MMA at a public forum in Mankato July 25; Michael J. Murray, M.D., testified in the Twin Cities August 1; and Raymond G. Christensen, M.D., testified in Duluth August 3. In addition, the MMA submitted written recommendations for improving the BMP's handling of sexual misconduct allegations.

See "Viewpoint" by Andrew J.K. Smith, M.D., president of the MMA, on page 34 for his thoughts on the report to the BMP. • • • • •

MMA Urges Changes in BMP Process

As the Minnesota Board of Medical Practice considers recommendations regarding its handling of sexual misconduct cases that would erode physicians' due process rights, the MMA has been urging a move in the opposite direction—improving the fairness of BMP processes. The MMA advocates the following changes:

- Allow a physician under BMP investigation to see the consultant report, which includes consultants' findings based on an analysis of med-

Changes continued on page 35



Viewpoint

• • •

Andrew J.K. Smith, M.D.
President, Minnesota Medical Association

Report to BMP Assails Right to Due Process

In the wake of shocking and highly publicized allegations of sexual misconduct by physicians, it is wise for the Minnesota Board of Medical Practice to consider ways to improve its handling of such cases. It is crucial to root out the rare sexual predator who violates the ethical code of our profession and seriously damages patients.

But what about the physician who is *falsely* accused of sexual misconduct? Or the physician whose attempt to comfort a patient is misconstrued? Obviously these doctors do not deserve to be driven out of the medical profession. The challenge for the BMP is to distinguish between them and the true sexual predator.

A recent report to the BMP, however, recommends that the board sweep together the innocent, the guilty, and those in need of education and treat them all with equal disregard for their right to due process under the law. The report was developed by the Consultation Group on Physician Sexual Misconduct, a group of consultants selected by the BMP.

The MMA opposes changing current law that makes allegations of misconduct confidential until the BMP finds there has been wrongdoing and takes disciplinary action. The report recommends that in cases of sexual misconduct, the notice of a

contested hearing be made public and the hearing be opened to the public. The MMA has raised the following objections:

- Newspaper articles publicizing a hearing on allegations of sexual misconduct would pronounce a death sentence on the physician's reputation and career. Punishment would be meted out before the hearing. Even if the physician was found innocent of wrongdoing, his or her practice would be destroyed by the publicity.

- Since contested hearings do not follow the same strict rules of evidence as a trial, hearsay and other inappropriate information would be released.

- Victims might hesitate to come forward if they had to testify in public.

The MMA opposes the recommendation that state medical boards be allowed to report criminal matters to law enforcement agencies. Current law not only allows but *requires* the BMP to report cases if failure to do so could pose a danger to the public. In addition, victims may directly report crimes to law enforcement officials.

This recommendation is probably the precursor of another BMP attempt to seek legislation that would allow it to share information gathered during its investigation with law enforcement officers. This would violate the physician's constitution-

al right not to disclose material that might be incriminating. Physicians are required by law to cooperate with a BMP investigation or they risk losing their license.

The report recommends that all sexual misconduct including minor "boundary violations" be disciplined and made public. According to Miriam Feldman's article in the May 1994 issue of *Minnesota Medicine*: "A typical boundary violation complaint might come from a woman patient whose doctor put his arm around her shoulder or placed his hand on her knee. The patient believed the doctor was making sexual advances while the doctor believed he was merely using a warm caring approach." Physicians are particularly vulnerable to charges of sexual misconduct. The very nature of our profession requires us to touch our patients. How could we practice if we were afraid to do so?

The report states that most complaints of a sexual nature are "due to a knowledge gap, some form of miscommunication, or a simple mistake." Clearly, education is the way to address such complaints. There is no reason to allow them to be published.

The report goes on to say: "While it was recognized that in the event of a false complaint, the physician's reputation and even ability to practice can be severely compromised if the charges are a matter of public record, the percentage of false complaints is thought to be very low." Even *one* false complaint published in the newspaper would be too many.

It is not necessary to sacrifice the physician's right to due process in order to improve the BMP's handling of sexual misconduct charges. We support recommendations that the BMP commit its full resources to address the current backlog of cases, educate its members about sexual misconduct, and use psychiatrists as consultants. In addition, the BMP should develop criteria to distinguish between the true predator and a physician whose mistakes could be corrected by education. • • • • •

ANNOUNCEMENTS

• • • • •

DHS ENFORCES PARTICIPATION RULE

The Department of Human Services is now enforcing a law requiring health care providers to participate in General Assistance Medical Care, Medical Assistance, and the MinnesotaCare program if they are to be reimbursed for other state health care programs, such as workers' compensation, the state employees' health insurance, the public employees' insurance program, Minnesota Comprehensive Health Association insurance, or plans offered to local or home rule charter city, county, and school district employees. Any physician who wishes to remain eligible for these state programs must be enrolled with DHS. For information on provider enrollment, call David Godfrey at DHS, 612/297-3880. If you have questions, call Molly Sigel at the MMA, 612/378-1875 or 800/999-1875.

• • •

PATIENT SATISFACTION SURVEY WILL BE PUBLISHED

The consumer satisfaction survey rating enrollees' satisfaction with their health plans will be published on Sunday, October 8. Newspapers throughout the state plan to give the survey high visibility. The survey does not rate patient satisfaction with individual physicians. If your patients have questions, you may refer them to their health plans.

MinnesotaCare legislation called for the consumer survey to make it easier for people to compare health plans. A study of physician satisfaction with health plans is also underway.

AMA Teams Up With Girl Scouts to Encourage Careers in Medicine

It's more than cookouts and s'mores for today's Girl Scouts. A new program, developed by the American Medical Association and the Girl Scouts of the U.S.A., allows Girl Scouts to explore a career in medicine. Scouts are paired with women physicians and spend a day getting an inside look at the medical profession. Aimed at girls between the ages of 11 and 17, this hands-on program also calls for independent study into various aspects of the medical profession, such as medical technology, community service, health care delivery, and the professional issues facing women in medicine.

The Physicians of Tomorrow Mentoring Program was developed by the American Medical Association's Advisory Panel on Women Physician Issues, chaired by Gail L. Gamble, M.D., of Rochester, Minnesota, past chair of the MMA Board

of Trustees, and by the Girl Scouts of the U.S.A. Local Girl Scout councils work with physicians in their community to put the program in action. Materials are provided by the AMA.

Mentoring programs are starting to spring up in communities all across the country, including cities in Minnesota. Currently, the Girl Scout Council of Greater Minneapolis is developing a new medical career interest badge and is looking for women physicians who would be willing to serve as mentors for Girl Scouts. If you would be willing to volunteer as a mentor, or if you would like more information about this program, call Susan Cornett at the Girl Scout Council of Greater Minneapolis, 612/535-4602. If you are interested in finding out if there is a program in a community outside the Twin Cities metropolitan area, call your local Girl Scout council.

• • • • •

Changes continued from page 33

ical records and a review of the case.

- Allow physicians to see the BMP investigative report so they can correct and challenge any inaccuracies early in the process.

- Classify correction orders, whereby physicians agree to certain stipulations in exchange for ultimate dismissal of the complaint, as private data. BMP discipline is classified as public and thus is accessible to anyone, but dismissal is not. The BMP classifies correction orders as public. The MMA, however, maintains that since the underlying complaint is ultimately dismissed, the orders should not be accessible to the public.

- Establish a statute of limitations for BMP action. Few people can remember the circumstances surrounding an event that was alleged

to have occurred 20 years ago, and the cost of maintaining documentation indefinitely is prohibitive.

- Allow physicians whose licenses have been revoked to submit an application to have it reinstated. The BMP can always reject the request, but at least the physician would have a chance to present any new evidence or change in circumstances.

- Limit immunity to activities conducted in good faith. Current law provides civil and criminal immunity for anyone who reports a physician to the BMP even if the report is made recklessly and maliciously. In addition, the law grants board members complete immunity for any action, transaction, or publication. The MMA believes that immunity should be limited to reports and actions conducted in good faith.

• • • • •

MMA Annual Meeting

Schedule of Events

Kahler Hotel, Kahler Plaza Hotel,
Radisson Hotel Centerplace

Wednesday, Sept. 27

1 p.m. to 6 p.m. (K)
General registration

2 p.m. to 4:45 p.m. (KP)
Board of Trustees meeting

5 p.m. to 6 p.m. (K)
1995 issues forum

6:30 p.m. to 8:30 p.m. (KP)
Welcome reception
Buffet and hospitality

K=Kahler Hotel
KP=Kahler Plaza Hotel
R=Radisson Hotel Centerplace

Thursday, Sept. 28

6:45 a.m. to 5 p.m. (K)
General registration

7 a.m. to 8 a.m.
Medical Student Section Caucus

7:15 a.m. to 9:15 a.m. (KP)
Component society caucuses:
• Ramsey
• Hennepin
• Greater Minnesota

8 a.m. to 8:45 a.m. (K)
Media briefing

9:30 a.m. to 11:00 a.m. (K)
House of Delegates (Session I)

11:15 a.m. to 12 noon (K)
AMA open forum

12:15 p.m. to 1:30 p.m. (KP)
Awards lunch

1:30 p.m. to 4:15 p.m. (K)
Reference committee open hearings

4:15 p.m. to completion (K)
Reference committee
executive session

4 p.m. to 5 p.m. (KP)
Resident Physician Section

4:30 p.m. to 6 p.m.
MEDPAC Annual Meeting (K)
Young Physicians Section (K)
Women Physicians (KP)

5 p.m. to 6 p.m.
AMA Delegation Meeting (KP)
Organized Medical Staff Section (K)

6:30 p.m. to 7 p.m. (R)
Pre-inaugural reception

7 p.m. to 9 p.m. (R)
President's inaugural
dinner and festivities

9 p.m. (R)
Afterglow reception

Friday, Sept. 29

7 a.m. to 8 a.m. (KP)
Board of Trustees
breakfast meeting

8 a.m. to 12 noon (K)
General registration

8 a.m. to 10 a.m. (KP)
Component society caucuses:
• Ramsey & Hennepin
• Greater Minnesota

10:15 a.m. to 3:30 p.m. (K)
House of Delegates (Session II)
(includes lunch)

3:30 p.m. (K)
Board of Trustees
organizational meeting

Spouse Activities

10 a.m.
Alliance fall meeting
Mayo Foundation House

12 noon
Alliance luncheon
Mayo Foundation House

ANNOUNCEMENTS

• • • • •

PHYSICIANS WANTED

The Minnesota Physicians Foundation of the Minnesota Medical Association is looking for members to serve on the Development Committee and the Medical Student Financial Assistance Committee. The Financial Assistance Committee meets twice a year to interview students who are applying for loans. The Development Committee meets quarterly and is currently raising funds for student loans. For further information call Karen A. Tourdot or Colleen Jensen at the MMA, 612/378-1875 or 800/999-1875.

• • •

MMA ALLIANCE PLANS FOR 'SAVE TODAY'

The Minnesota Medical Association Alliance, a volunteer organization of physicians' spouses, is participating in the American Medical Association Alliance's nationwide anti-violence initiative, "SAVE: Stop America's Violence Everywhere." The centerpiece of the year-round program is "SAVE Today," an event on October 11, 1995. Activities are planned throughout the state. If you would like to receive anti-violence brochures, buttons, or bumper stickers, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875. To receive an AMA SAVE program kit, contact the AMA Alliance at 515 North State Street, Chicago, IL 60610; 312/464-4470.

MMA House of Delegates Will Consider Resolutions, Set Policy at 1995 MMA Annual Meeting

The 1995 MMA House of Delegates will convene in Rochester Thursday, September 28, and Friday, September 29, to take action on resolutions that will set the Minnesota Medical Association's course for the coming year. As *The Monitor* goes to press, the following resolutions have been submitted.

Res. 1, Medical Decision-Making for Wards of the State

Introduced by: Steele County Medical Society (SCMS)

Resolves that the MMA study Minnesota law and regulations regarding do-not-resuscitate, do-not-intubate, other withdrawal-of-care orders, and advanced directives for state wards.

Res. 2, Appointments of Members to the Minnesota Board of Medical Practice

Introduced by: SCMS

Resolves that the MMA seek legislation requiring legislative advice and consent to the governor's appointments to the BMP.

Res. 3, Suspension or Removal of BMP Members

Introduced by: SCMS

Resolves that the MMA propose legislation to provide processes for suspending and removing BMP members.

Res. 4, Self-Treatment or Treatment of Family Members

Introduced by: MMA Committee on Ethics and Medical-Legal Affairs

Resolves that the MMA adopt the AMA Council on Ethical and Judicial Affairs' opinion that physicians generally should not treat themselves or members of their immediate family unless there is an emergency.

Res. 5, Ethical Issues in Managed Care

Introduced by: MMA Committee on Ethics and Medical-Legal Affairs

Resolves that the MMA adopt the AMA Council on Ethical and Judicial Affairs' guidelines regarding ethical issues in managed care.

Res. 6, Bylaws Revisions

Introduced by: MMA Board of Trustees

Resolves that the MMA adopt bylaws revisions approved by the MMA Board of Trustees.

Res. 7, Direct Access to Preventive Health, Diagnostic, and Treatment Services of Obstetrician-Gynecologists

Introduced by: The Minnesota Obstetrical and Gynecological Society

Resolves that MMA adopt policy supporting a woman's right to direct access to preventive health, diagnostic, and treatment services by obstetricians and gynecologists.

Res. 8, Rural Prepaid Medical Assistance Program (P.M.A.P.)—Study of Itasca Medicaid Demonstration Project

Introduced by: Upper Mississippi Medical Society

Resolves that the MMA study and report to the MMA membership regarding the Itasca Medicaid Demonstration Project's effect on access, quality, and cost of prepaid Medical Assistance health care in rural Minnesota and pursue legislation to delay the implementation of rural P.M.A.P. until its impact can be studied.

Res. 9, Ban on Assault-Style Weapons

Introduced by: Hennepin County Medical Society (HCMS)

Resolves that the MMA support a ban on the manufacture and sale of

Resolutions continued on page 38

Resolutions continued from page 37

assault-style weapons and support the development of non-lethal, defensive weapons to eventually replace most handguns.

Res. 10, Business Practices by Hospitals, Clinics, and Other Health Care Providers

Introduced by: HCMS

Resolves that the MMA support the provider practice of supplying itemized bills to patients and further resolves that the MMA welcome close scrutiny of business practices.

Res. 11, Minnesota Department of Health—Physician Clinic Survey

Introduced by: HCMS

Resolves that the MMA work with the Minnesota Medical Group Management Association and the Minnesota Department of Health to redesign the Physician Clinic Survey so that it utilizes accepted accounting methodology, and further resolves that the MMA request that MDH provide a cost-and-time analysis of future administrative burdens on providers.

Res. 12, Direct Contracting

Introduced by: HCMS

Resolves that the MMA study the direct-contracting model and, if appropriate, develop educational materials, seminars, or other similar activities.

Res. 13, Conflict-of-Interest Laws and Corporate-Directed Medical Practice

Introduced by: HCMS

Resolves that the MMA recommend to the Legislature that all entities with any control of physician practices be subject to the same conflict-of-interest laws as physicians and physician-controlled groups and that the MMA call on the AMA to request the same fair provisions from national regulations and legislators.

Res. 14, Center for Cross-Cultural Health

Introduced by: HCMS

Resolves that the MMA assist in the development, implementation, and promotion of the Center for Cross-Cultural Health, which will serve as a clearinghouse, resource, and research center for health care providers, and support its continued operation.

Res. 15, State Funding of Medical Services

Introduced by: HCMS

Resolves that the MMA review the state's role in the financing and delivering of medical care; develop position statements regarding the reorganization and financing of the Medical Assistance and MinnesotaCare programs; and continue to promote broad-based equitable funding sources for state medical programs.

Res. 16, Changing the Name of the Hennepin County Medical Society

Introduced by: HCMS

Resolves that the name, "Hennepin County Medical Society," be changed to "Hennepin Medical Society."

Res. 17, Immunizations

Introduced by: HCMS

Resolves that the MMA recommend legislation that requires immunization coverage to be included in the basic benefit package of all insurance companies operating in Minnesota.

Res. 18, Continuous Coverage for Children on Medical Assistance

Introduced by: HCMS

Resolves that the MMA work with the Medicaid managed care plans to reimburse providers for the medical care of children from high-risk areas (despite managed care assigned membership) and that the MMA encourage providers to work with these patients and Hennepin County Economic Assistance to ensure that patient enrollment is changed to the appropriate Medicaid managed care plan.

Res. 19, Support for Media Violence Campaign

Introduced by: HCMS

Resolves that MMA members strongly support the MMA's "Stop the Media Violence" campaign and that the MMA encourage all physicians to instruct the parents of their pediatric patients on the MMA's "10 Tips on Media Violence."

Res. 20, Smoking at Building Entrances

Introduced by: HCMS

Resolves that the MMA urge the Legislature to prohibit smoking within 75 feet of any entrance to a facility in which smoking is proscribed by law.

Res. 21, Trauma System in Minnesota

Introduced by: HCMS

Resolves that the MMA develop policy regarding a trauma system in Minnesota and, if appropriate, develop legislative recommendations.

Res. 22, Physical Therapy Assistants

Introduced by: Minnesota Physiatric Society

Resolves that the MMA support legislation to allow physical therapist assistants to treat patients without prior physical therapy evaluation when prior physician evaluation and recommendations have been made.

Res. 23, The Use of Anencephalic Neonates as Organ Donors

Introduced by: MMA Committee on Ethics and Medical-Legal Affairs

Resolves that the MMA adopt policy opposed to the AMA Council on Ethical and Judicial Affairs' opinion that it may be permissible, under certain circumstances, to use anencephalic neonates as organ donors.

Res. 24, Patient Record Confidentiality

Introduced by: Zumbro Valley Medical Society (ZVMS)

Resolves that the MMA support permanent repeal in 1996 of the sun-

set provision of the present patient record confidentiality rule.

Res. 25, Repayment of Student Loans

Introduced by: ZVMS

Resolves that the MMA protest the law that revokes the license of physicians who fail to repay a state or federally secured student loan. It further resolves that the MMA reaffirm its policy that all student loans should be repaid as rapidly as possible and resolves that the MMA work with public bodies to develop mechanisms to ensure the full repayment of medical student loans.

Res. 26, Tort Reform

Introduced by: ZVMS

Resolves that the MMA work to have the tort reform provisions of the Quality and Coverage Act reintroduced to the 1996 Legislature.

Res. 27, 2 Percent Provider Tax

Introduced by: ZVMS

Resolves that the MMA continue to work for a substitute for the 2 percent provider tax, such as a tax on tobacco products.

Res. 28, Maintaining Momentum in the Next Legislature

Introduced by: ZVMS

Resolves that the MMA continue to promote provisions of the Quality and Coverage Act and submit any revisions or augmentation that seems appropriate early in the 1996 legislative session and that this activity be given high priority in 1996.

Res. 29, Telemedicine

Introduced by: ZVMS

Resolves that the MMA develop a task force on telemedicine and teleradiology that will develop a white paper on the needs for guidelines and recommendations for implementation and use of these technologies.

Res. 30, Stop the Violence Campaign

Introduced by: MMA Committee on Communications

Resolves that the MMA continue

to work with the attorney general's office and others to create a broad coalition to promote violence awareness and prevention and that the MMA explore new technology such as the "V-Chip" that would allow parents to lock out violent programs, channels, and commercials. It further resolves that the MMA support a rating system for television programs.

Res. 31, Post-Partum Hospital Stay and Nurse Home Visits

Introduced by: ZVMS

Resolves that the MMA develop legislation requiring insurance coverage for the option of 48-hour postpartum hospital stays and one or more nurse home visits, as needed, after hospital discharge.

Res. 32, Ethical Conflicts with Managed Care

Introduced by: ZVMS

Resolves that the MMA sponsor a symposium on ethical conflicts raised by managed care with hopes that the MMA can take a position on ways to resolve ethical dilemmas created by managed care.

Res. 33, Bicycle Safety

Introduced by: Range Medical Society (RMS)

Resolves that the MMA support legislation that mandates the use of helmets for children under the age of 18 while operating bicycles, off-road vehicles, motorized wheeled vehicles, or snowmobiles.

Res. 34, Water Safety

Introduced by: RMS

Resolves that the MMA support legislation that mandates the use of life jackets or flotation devices for children under the age of 18.

Res. 35, AIDS Testing

Introduced by: RMS

Resolves that the MMA support legislation that would treat HIV like other communicable diseases.

Res. 36, Under-Age Chemical Use

Introduced by: RMS

Resolves that the MMA support

legislation that would revoke until the age of 21 the driver's license of any minor who is found driving with a blood alcohol level of 0.02 mg %.

Res. 37, Snow Safety

Introduced by: RMS

Resolves that the MMA support legislation that mandates helmets for children under the age of 18 while skiing or snowboarding downhill at commercial downhill skiing facilities.

Res. 38, Gun Control

Introduced by: HCMS

Resolves that the MMA promote stricter enforcement of gun laws and support legislation advocating tighter handgun control laws so that only individuals with a legitimate need for lethal self-defense shall be permitted to own handguns.

Res. 39, Medical Information Systems

Introduced by: HCMS

Resolves that the MMA convene a group of physicians and entity representatives to discuss the use of integrated computer networks to electronically share information and avoid duplication of efforts.

Res. 40, Nursing Home Reimbursements

Introduced by: HCMS

Resolves that the MMA encourage the AMA to ask HCFA to revise rules governing Medicare reimbursement for skilled nursing facility care so that payments would not be contingent on a patient being hospitalized three consecutive days, and further resolves that the MMA and AMA work to educate Congress on the financial implications of this rule.

Res. 41, Preventive Services Guidelines

Introduced by: HCMS and Ramsey County Medical Society (RCMS)

Resolves that the MMA support the continued development of the Preventive Service Guidelines and assist in their promotion, distribution, and implementation. It further resolves that the guidelines be con-

Resolutions continued on page 40

Resolutions continued from page 39

sidered a floor on preventive services and not be used to limit new, cost-effective, preventive health care practices that might be developed in the future or be used as a guide for reimbursement.

Res. 42, Cost of Copying Medical Records

Introduced by: RCMS

Resolves that the MMA support legislation requiring health plans to reimburse the cost of copying a patient's medical record if the patient must change physicians because of health plan requirements and the transfer of medical records is required.

Res. 43, Tobacco Tax Increase

Introduced by: RCMS

Resolves that the MMA support legislation in 1996 to increase the cigarette tax and use a percentage of the funds for smoking prevention and health care.

Res. 44, Obstetrician-Gynecologists as Primary Care Providers for Women

Introduced by: RCMS

Resolves that the MMA support the designation of obstetrician-gynecologists as primary care providers for women.

Res. 45, Retroactive Denials

Introduced by: RCMS

Resolves that the MMA work with third-party payers and the MDH to establish a mechanism to identify the problems resulting from retroactive denial and to propose solutions.

Res. 46, Multiple Management Information Systems in Health Care

Introduced by: RCMS

Resolves that the MMA recommend that a basic data set and compatible management information systems be used by all health care organizations.

Res. 47, Point-of-Service Requirement

Introduced by: Minnesota Ortho-

paedic Society

Resolves that the MMA continue in 1996 to pursue legislation that would require each health plan operating in the individual, small group, or large group market to offer a point-of-service option in each of its markets and require the cost of this option to be actuarially justified.

Res. 48, Opposition to Mandatory Reduced Hospital Stays

Introduced by: Minnesota Obstetrical and Gynecological Society

Resolves that the MMA support the Minnesota Obstetrical and Gynecological Society's opposition to mandatory one-day hospital stays for vaginal delivery and three-day stays for major abdominal surgery including cesarean sections.

Res. 49, Air Quality

Introduced by: Environmental Health Subcommittee of the MMA Committee on Public Health and Preventive Medicine

Resolves that the MMA support legislation to protect human health and control air pollution and further resolves that air quality standards should be established using the best available scientific data.

Res. 50, HIV Testing of Pregnant Women

Introduced by: MMA Committee on Public Health and Preventive Medicine

Resolves that the MMA support the routine offering of the HIV test to all pregnant women and resolves that the MMA disseminate information about this issue to physicians.

Res. 51, Pediatric Immunization Standards

Introduced by: MMA Committee on Public Health and Preventive Medicine

Resolves that the MMA endorse and disseminate the Standards for Pediatric Immunization Practices recommended by the National Vaccine Advisory Committee.

Res. 52, Guidelines for Adolescent Preventive Services

Introduced by: MMA Committee on Public Health and Preventive Medicine

Resolves that the MMA convene an ad hoc task force of health care payers and providers to explore opportunities to implement the AMA Guidelines for Adolescent Preventive Services. • • • • •

Specialty Specific Coding Institutes

The Minnesota Medical Association and Profile Group are presenting specialty specific coding institutes for CPT/HCPCS and ICD-9 coding of physician services for primary care, orthopedics, ophthalmology, and obstetrics and gynecology. The two-day program is designed to be an intensive follow-up to the general coding seminars. The schedule of the remaining seminars is as follows: Obstetrics and Gynecology, September 13-14, St. Cloud; Primary Care, September 13-14, St. Cloud. The tuition for each two-day institute is \$260 plus \$40 for the extensive training manual.

For further information, call Vicki Westling, MMA, 612/362-3764 or 800/999-1875. • • • • •

The Monitor

SEPTEMBER 1995

• • •

PRESIDENT

Andrew J.K. Smith, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

• • •



NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA PHYSICIANS INSURANCE AGENCY

3433 Broadway St. NE Suite 375
Minneapolis, MN 55413



Please send me information about the following insurance products:

- | | |
|---|--|
| ☐ Term Life | ☐ Short Term Disability |
| ☐ Universal Life (Fixed and variable)* | ☐ Medical & Dental |
| ☐ Retirement Plans | ☐ Comprehensive Major Medical |
| ☐ Whole Life | ☐ Excess Major Medical |
| ☐ Annuities (Fixed and variable)* | ☐ Medicare Supplemental |
| ☐ Accidental Death & Dismemberment | ☐ Long Term Care |
| ☐ Non-cancelable Individual Disability | ☐ Professional Overhead Expense |

**Variable universal life and variable annuities are offered by our network of independent insurance counselors through Washington Square Securities, Inc.*

Name _____

Address _____

City _____ State _____ Zip _____

My need is immediate, please have the MPIA counselor in my area contact me.

My phone number is _____ .

Last month we said there were new services through Minnesota Physicians Insurance Agency. We meant it!



Upcoming seminars we promised:

September 26, 8am-9:30am
Compensation and benefits in the changing practice environment.

October 17, 8am-9:30am
How to make your qualified retirement plan simple to administer and easy to communicate to employees, while retaining investment choice.

November 16, 6pm-7:30pm
Strategies to maximize retirement income by decreasing your tax burden.

Space is limited. Call now to reserve your seat.

As part of Minnesota Medical Business Resources financial services, MPIA brings you valuable new services including:

- ★ Tax favored programs to help you build more capital for retirement.
- ★ New low cost quality life insurance and favorable underwriting on disability income protection.
- ★ Insightful estate planning, retirement planning and practice succession seminars.
- ★ Seminars, like the one on September 26, to help practice managers.

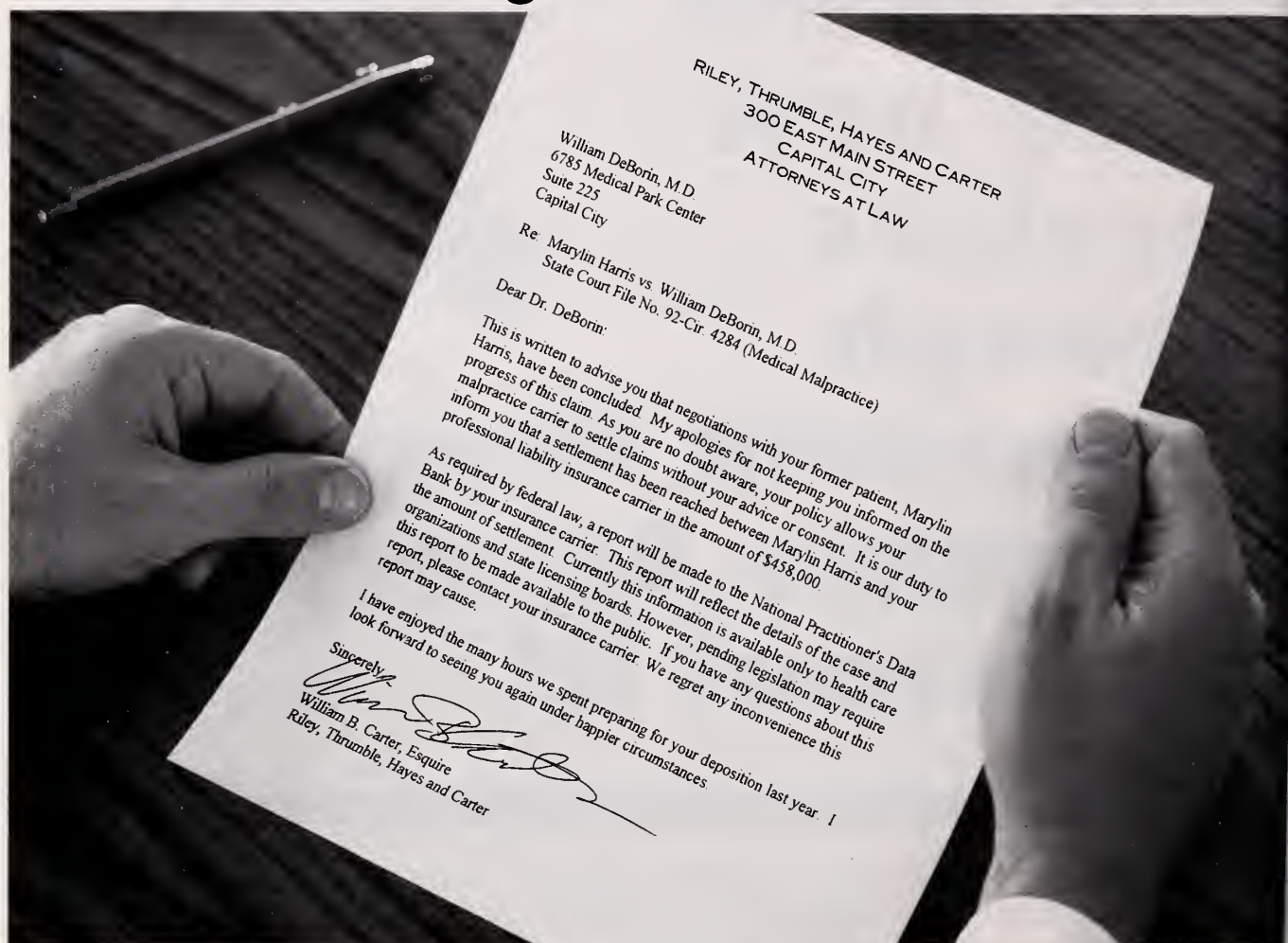
For assistance with your insurance or financial needs or to reserve your place at these seminars, please call MPIA at (800) 298-6627.

MPIA

MINNESOTA PHYSICIANS
INSURANCE AGENCY

*A business corporation
of the MMA and HMS.
A MMBR Company.*

Medical Protective Policyowners **NEVER** get letters like this!



Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--**no strings attached!** In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's

800/344-1899



Reporting Obligations Under the Vulnerable Adults Act

Changes to the Vulnerable Adults Act may increase the instances when physicians are required to report maltreatment of vulnerable adults. Here's a brief overview of who must report when and what.

Sheva J. Sanders, J.D.

After heated debate, the 1995 Minnesota Legislature substantially amended the Vulnerable Adults Act. First passed in 1980, the act is intended to protect patients of hospitals, nursing homes, or other licensed facilities, as well as individuals with a physical, mental, or emotional dysfunction that impairs their ability to protect themselves.

Among the new amendments, most of which take effect October 1, are several changes to the provisions requiring physicians to report maltreatment of vulnerable adults. This article concentrates primarily on these new reporting obligations, but also briefly summarizes certain other significant changes wrought by the amendments.

The language of the amendments is expansive and ambiguous and there are harsher penalties for not reporting maltreatment. Failure to report is now a gross misdemeanor and may constitute grounds for disciplinary action by professional licensing boards. Consequently, physicians would be wise to file a report whenever they suspect that a vulnerable adult may have been maltreated.

The amendments make it more likely that providers will encounter reportable events. A notable consequence of increased reporting is that the confidentiality of the physician-patient relationship will often be compromised. There was opposition to amendments because of concern that certain patients, such as victims of

domestic abuse, might be discouraged from seeking professional assistance for fear of unwanted government involvement.

Who Must Report?

The law requires physicians who have reason to believe a vulnerable adult is being or has been maltreated to immediately report the maltreatment to either the facility where the maltreatment occurred or to the appropriate government agency, now referred to as the "common entry point."*

This mandate is similar to the old law, but it contains some subtle and not-so-subtle distinctions.

The law defines mandated reporters as professionals or their delegates "while" engaged in the provision of professional services. The use of the word "while," in contrast to the old law's use of the phrase "who is engaged in," might be interpreted to limit the scope of the responsibility to times when the reporter is engaged in the provision of professional services.

When Are Professionals Required to Report?

The act changes the language used to describe the degree of certainty a professional must have to make a report, but this change appears to be without substance; under both the old and the new law very little is required. Physicians are now required to report whenever they have "reason to believe" a vulnerable adult has been or

is being abused. It is likely that knowledge of events or facts sufficient to create a reasonable suspicion would be considered sufficient to trigger a reporting obligation.

It does not matter when the maltreatment occurred. An instance of maltreatment must be reported even if it substantially predated the time when the professional became aware of the maltreatment. An unresolved question is whether the adult must be a vulnerable adult at the time the report is made, or whether it is sufficient that the adult was vulnerable at the time of the maltreatment. Given the new emphasis on apprehending and penalizing those who commit maltreatment, the latter interpretation seems possible.

The obligation to report extends to the maltreatment of any vulnerable adult, regardless of whether the professional has a treatment relationship with the adult. For example, if a psychologist became aware that a spouse of a patient had been emotionally abused, the provider might be obligated to make a report, assuming the psychologist determined that the spouse was a vulnerable adult, that the particular abuse constituted a reportable event, and that no exceptions applied.

* Under the amended law, each county will designate a single "entry point" responsible for receiving reports of maltreatment. Under the original law, reports could be made to a number of different agencies.

Who Is a Vulnerable Adult?

The law expands the definition of vulnerable adult. Previously, if an adult's ability to report instances of abuse was impaired, then the adult was considered vulnerable and was protected by the law. Under the new law, adults are considered vulnerable if they have a malady or disability that impairs their ability to protect themselves from maltreatment, without regard to their ability to report.

Under the new law, an adult who meets the following two requirements is considered vulnerable:

1. the individual has a physical or mental infirmity or a physical, mental, or emotional dysfunction that impairs his ability to provide for his own care without assistance (care includes food, shelter, clothing, health

care, or supervision); and

2. the infirmity or dysfunction impairs his ability to protect himself from maltreatment.

As for the first requirement, virtually any person presenting to a provider might be said to exhibit some infirmity or dysfunction and, by definition, to be seeking assistance in his own care. Almost all patients will, given a literal reading of the law, exhibit the characteristics necessary to meet the first prong of the test.

The second prong of the test also can be interpreted broadly. The infirmity or dysfunction must impair the adult's ability to protect himself from maltreatment. The word "impair" can be construed to include any deviation from optimum ability. It is con-

ceivable that any person with more than an insignificant physical or mental disability or illness, or any person whose functional ability is compromised in any way, say through substance abuse, would be considered a vulnerable adult.

The most obvious problem with this definition is that the type of maltreatment to which the adult is vulnerable need not be the same type of maltreatment actually perpetrated against the adult. For example, it appears that repeated verbal harassment of a competent patient whose physical disability makes him vulnerable to assault would be reportable maltreatment. As the law is written, if an adult is considered vulnerable, all maltreatment is reportable.

Given the potentially broad read-

One MMA Member Makes a Big Difference

By Lorrie Holmgren

Much credit for the defeat of a felony penalty in the Vulnerable Adults Act goes to rank-and-file MMA member Benjamin Whitten, M.D.

In Whitten's 10 years as a Minnesota Medical Association member, he had never been involved in association activities, nor was he active in state or national politics. But when he received an MMA Legislative Alert on the Vulnerable Adults Act, Whitten plunged into an all-out effort to defeat the proposed felony penalty for criminal neglect. The MMA and other organizations feared that such a penalty would lead to criminal prosecution of bad medical outcomes, which would have a chilling effect on physician willingness to care for elderly and disabled individuals.

"It was absolutely crystal clear the moment I saw the MMA Alert that this proposal had the potential to cause great harm to patients, physicians, and other caregivers. I could see that if this bill became law, it could be—and would be—exploited for political ends," Whitten says.

Whitten had good reason to be alert to the dangers this bill posed. Several years ago, one of his five partners in a general internal medicine practice in Minneapolis and Minnetonka treated a hospital-

ized woman with congestive heart failure who gasped and choked when she tried to swallow but couldn't tolerate intravenous feeding. Although the

patient received exemplary care, she died. The outcome was not unexpected, but it turned into a two-year nightmare for the practice. A right-to-life activist, unrelated to the deceased, seized upon the patient's death to further a cause, according to Whitten. The activist prompted a television news team to broadcast a sensational story and pressured the Board of Medical Practice to investigate the death. Although the BMP investigation eventually found that the woman's care was appropriate, compassionate, and kind, this incident had a devastating effect

on the physician involved and disrupted the practice of all the partners for two or three years. If criminal prosecution had been possible, the impact could have been much worse.

"I saw this bill as a watershed," says Whitten. "We're in a tough business. Our patients don't live forever; some have bad outcomes. This bill created the prospect of prosecutors looking at every bad outcome and saying it could have been prevented."

According to Whitten, many supporters of the



Benjamin Whitten, M.D.

ing of the law and the stiff penalties for noncompliance, providers would be well advised to assume that a patient who exhibits any mental or physical characteristic or condition that could reasonably be expected to increase vulnerability to any type of maltreatment is a vulnerable adult.

In addition, any inpatient or client of a licensed facility is considered a vulnerable adult. This "situational" test is consistent with the old law.

What Is Maltreatment?

Only conduct that constitutes maltreatment must be reported under the act. The act defines maltreatment as neglect, abuse, financial exploitation, or a physical injury that is not reasonably explained. With the exception of physical injury, the cate-

gories cover a broad range of misbehavior.

As in the old law, abuse is defined to encompass a number of criminal activities. The amendments expand the definition of abuse to include aiding and abetting as well as attempting the crimes. In addition, any conduct that is not an "accident or therapeutic conduct" (see "What Are the Exceptions" below) and that produces or could reasonably be expected to produce physical or emotional distress or injury, constitutes abuse. For example, repeated or malicious humiliating, derogatory, or disparaging conduct is considered abusive.

Neglect occurs when a vulnerable adult is not supplied with reasonable and necessary care or services. Apparently, it can occur even when

the adult has no caregiver; in other words, a vulnerable adult could neglect himself.

Financial exploitation involves the misappropriation or misapplication of a vulnerable adult's property.

What Are the Exceptions?

Acts that otherwise meet the definition of maltreatment will not be considered maltreatment if they fall within one of the law's exceptions. However, the exceptions are narrowly defined and of limited use. Two of the most significant are "accidents" and "therapeutic conduct."

An accident is an event that is sudden, unforeseen, unexpected, and essentially unpreventable. Therapeutic conduct is defined as acts that are done in good faith and in the best

bill want the same thing physicians want—good care for a vulnerable population—but "the road to hell is paved with good intentions," he adds.

"If the [original] bill had become law, the effect on elderly chronically ill people would have been the exact opposite of that intended by the bill's authors," says Whitten. "Why? Because physicians who fear criminal prosecution would refuse to become involved or to make the tough calls."

Convinced that the felony penalty would have a chilling effect on the practice of medicine, Whitten began to contact legislators. Armed with the MMA Legislative Alert, he went to the Capitol, where he talked to Sens. Richard Cohen, DFL-St. Paul, Dean Johnson, IR-Willmar, Gary Laidig, IR-Stillwater, and Roy Terwilliger, IR-Edina, then added a handwritten message to the MMA Alert and stopped by the office of Reps. Matt Entenza, DFL-St. Paul, and Howard Orenstein, DFL-St. Paul. That was day one. In the weeks to come, Whitten talked to countless legislators on the committees that were considering the Vulnerable Adults bill as well as to several reporters.

The MMA supported his efforts. "I couldn't have been effective without the help of MMA staff," says Whitten. "Mary Prentnieks [then director of MMA's legal affairs] helped me understand the key points of the bill and gave me the information I needed to make rational arguments and to exert real leverage."

Whitten also galvanized his fellow physicians into action, contacting colleagues across the state. His efforts snowballed as each physician called

seven or eight others. Whitten didn't confine his contacts to physicians but branched out to include attorneys, other caregivers, and neighbors. He targeted his efforts at people who lived in the districts of key legislators and gave them a clear charge: "Call your representative today and ask him or her to take this specific action."

Whitten's yeoman's efforts paid off. "Dr. Whitten's involvement shows how much impact an individual MMA member can have," says David Renner, MMA director of legislation and public policy. "In the final days before the vote, it could have gone either way. There was tremendous pressure from the attorney general to pass this bill. But when legislators started to hear from a great many physicians, they paid attention and the felony penalty was defeated."

Whitten says he gained a new respect for the legislative process. "Legislators work very hard and try to do the right thing, but they have to work on the basis of the information they have. If legislators don't hear from people with a particular viewpoint, they can't take those ideas into account."

After his successful first-time experience, Whitten has chosen to continue his MMA involvement; he has been appointed to the MMA's Committee on Legislation and will serve as an alternate in the MMA House of Delegates at this year's Annual Meeting.

Lorrie Holmgren is manager of member communications for the Minnesota Medical Association and editor of The Monitor.

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree™

Minneapolis 667-0705
©1995 Norwest Bank Minnesota N.A.
Member FDIC

interest of the vulnerable adult. This exception may not be applicable to deprivation therapy (the definition speaks only of provision of services), nor to any conduct that is not objectively in the best interest of the patient; thus, a mistaken course of treatment that had some adverse physical side effects might be considered abusive, even though the decision to use the treatment was not negligent. A "single mistake" in the provision of therapeutic care is not reportable if it causes insignificant injury, is immediately reported internally, and is appropriately documented.

There also are exceptions for patients who choose to withdraw or refuse medical care, provided the decision-maker has authority to make such choices and the decision is "within the boundary of reasonable medical practice." Exceptions also exist for patients who choose to rely on prayer as a healing agent; the decision must be in good faith and consistent with either the prior practice or expressed intentions of the vulnerable adult.

As a practical matter, providers

should carefully consider reporting any decision to withdraw or refuse medical care or to rely on prayer that does not meet the specific terms of the applicable exception.

As for removing life-sustaining treatment, it may be difficult to determine with any assurance what constitutes "reasonable medical practice." Accordingly, providers might find themselves reporting many such decisions that would previously have been made in privacy. Whether or not the act's treatment of this issue heralds a period of greater government involvement in such decision-making remains to be seen; however, the act certainly provides a mechanism for such involvement.

What Is the Penalty?

The most controversial aspect of the act is the provision dealing with criminal penalties. The failure to report maltreatment of a vulnerable adult constitutes a criminal offense—a gross misdemeanor. The act also creates a number of new crimes specific to the abuse, neglect, or financial exploitation of vulnerable adults.

Much of the conduct that is punishable under the act would likely have been punishable under other provisions of the criminal code; for example, as assault or battery. However, the creation of a new category of crimes specific to the health care industry may increase enforcement. It remains to be seen whether prosecutors will use these provisions to prosecute conduct that previously would have been addressed in a civil malpractice action, if at all. Will decisions to disconnect life support, for example, be prosecuted as abuse if the decision does not fall within the statutory exception to the definition of abuse?

Is There Immunity?

Physicians who make a good-faith report are granted immunity from any civil or criminal liability that might otherwise result from making the report or from participating in the investigation, or for failure to comply fully with the reporting obligation imposed by the act.

Conclusion

Some of the features of the act are laudable. Its goal of providing incentives and mechanisms for the efficient reporting of maltreatment of adults who cannot protect themselves is certainly praiseworthy. Civil and criminal sanctions for bad actors, streamlined reporting mechanisms, and an expanded definition of maltreatment might work to protect adults who previously would have suffered. On the other hand, claims that the act paints with too broad a brush and without regard to competing interests are not easily dismissed. Disregard for the autonomy of disabled individuals, a lack of concern for the confidentiality of the physician-patient relationship, and the potential for the characterization of benign and caring conduct as misconduct all are legitimate causes for concern. Perhaps experience will convince the Legislature to revisit and carefully revise the law so that its purposes may be served in a less problematic manner. MM

Sheva Sanders is an attorney in private practice with Lindquist & Vennun.

A
Cost
Effective
Continuum
of
Care



We're committed to providing a continuum of extended critical care for the acutely ill, medically complex patient, and to cost effective delivery that includes:

- Collaborative care with referring facilities and fast response time for patient assessment, determination and transfer
- Ongoing, periodic case manager notification of clinical condition and medical progress
- Board certified physicians and experienced clinical staff
- Technologically advanced therapies

With a full range of outcomes oriented programs ... Medically Complex Program, Ventilator and Respiratory Care Program, Wound Care Program and Low Tolerance Rehabilitation Services, our costs are based on patient acuity.



A Subsidiary of Translational Hospitals Corporation

612-588-2750

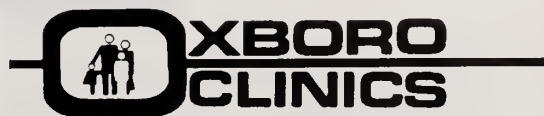
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient, Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

OUTPATIENT PSYCHIATRIST

HealthPartners is seeking an outpatient, BE/BC psychiatrist challenged by innovations in team-based, interdisciplinary psychiatric care. HealthPartners' Psychiatrists practice in an evolving organized care system with opportunities to work closely with primary and specialty care physicians as well as mental health professionals from a variety of backgrounds. Specialty interests in affective and anxiety disorders, and disability management are also sought.

HealthPartners staff division was established in 1957 as a staff model HMO offering its physicians a balanced lifestyle, excellent salaries and a generous benefit package that includes paid malpractice.

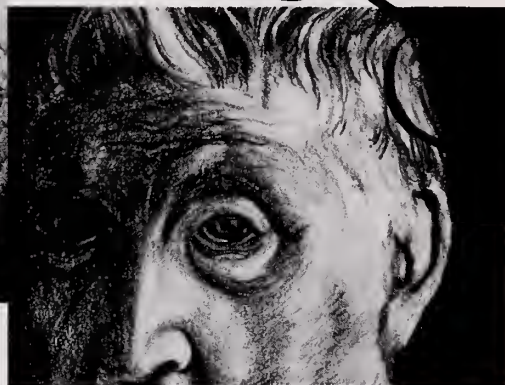
Psychiatrists will join a department of 15 full time psychiatrists and 80 clinicians that provide service in adult and child, mental/chemical health and health psychology for over 250,000 HealthPartners members. To inquire, please call (612) 883-5337, 1-800-472-4695, or send CV to: **HealthPartners**, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

HealthPartners' mission is to improve the health of our members and our community.

EO/AA Employer



HealthPartners



A COMMITMENT TO

Quality

STARTS WITH

Quality Peer Review

The Minnesota Medical Association is proud to announce its Peer Review Consultation Services. This program, tailored to meet state and federal guidelines, is designed for use by hospitals, clinics and other organizations that need peer review by an impartial third party.

Reviewing physicians

- ♦ are either board certified or eligible in appropriate specialties or subspecialties
- ♦ have been trained in objective peer review procedures
- ♦ will conduct reviews on-site or off
- ♦ will provide an advisory report containing background information, findings of fact and conclusions

To obtain confidential peer review consultation services, call the MMA and ask for Peer Review Consultation Services. In the Twin Cities call 378-1875. Outside the metro area call toll free, 1-800-999-1875.

The MMA is committed to helping you maintain and improve the quality of health care.

Call us today.



MMA

Minnesota Medical Association

A Dream Fulfilled

Dr. Mary Rowland's memoirs, recounted in the book "As Long as Life: The Memoirs of a Frontier Woman Doctor" (Storm Peak Press, 1994) tell the intriguing tale of a 19th century woman's struggles and triumphs as a frontier physician.

Barbara P. Yawn, M.D., M.Sc.

From Kansas to Oregon, Dr. Mary Rowland follows the opening of the West. But this is not a story about taming the wild frontier; it is the story of a remarkable woman who lives her dreams and fulfills her ambitions as a frontier physician. The book is a compilation of Dr. Mary Canaga Rowland's diary entries and the tales she told her family, as edited by a nephew.

In her early teens, Mary Canaga left her family in Red Willow, Nebraska, in 1885 to continue her education and to teach. By age 16 she had obtained a teaching certificate and began teaching in a small school in Herndon, Kansas. Her mentor in Herndon was a man 10 years her senior, Walter Rowland, a former school teacher who became a lawyer and a physician. Shortly after Mary married Walter Rowland, he left to spend a refresher year in medical school. He returned to his practice in Herndon and encouraged his wife to fulfill her dream by attending medical school and returning to practice with him.

Mary Rowland began her medical training in 1891 at age 18 in a Kansas medical school. After one year of the two-year program, she transferred to a women's medical college in Kansas City, Missouri. The women's school offered a more comfortable learning environment where teachers and fellow students did not question the rights and privileges of a woman to learn about human anat-

my and physiology.

In Rowland's memoirs, both the contrasts and similarities to life in modern rural America are striking. Technology and education have changed greatly in the past century, but attitudes and personal struggles have changed less. Armed with little more than a basic knowledge of anatomy and physiology, a horse and buggy, splints, poultices, Epsom salts, and morphine, this woman tackled farm injuries, complicated confinements, and even the flu epidemic of 1918 to 1919.

She also confronted the ignorance of the populace (and of some poorly trained doctors) regarding simple public health measures, personal responsibility, and mental health. In an era when some medical schools considered it indecent for women to learn about anatomy and barred their entry, it is not surprising that many of Rowland's prospective patients considered it "unseemly" for a woman to practice medicine. However, in each of her several community practices in Herndon, Kansas; Omaha, Nebraska; and Lebanon and Salem, Oregon, Rowland found an appreciative group of patients and a small group of supportive friends and male colleagues.

Although medical technology has changed, the story is similar to what could be written by several successful women physicians who live and work today in our nation's frontier communities. It is a story that can be read at many levels and easily embellished

upon by the experiences of any modern physician. You don't have to be a frontier physician (or even a woman physician) to feel frustration when unable to heal a patient, or to experience the irony of great praise when a treatment is successful and blame when it is not.

This book is deceptively short and quick to read, but the reverie it summons may linger. Some of the anecdotes about medical cases and personal lives may haunt the reader with their similarity to modern life in the medical profession. **MM**

Barbara Yawn is a family physician and director of clinical research at the Olmsted Medical Group in Rochester, Minnesota. She is a member of the Minnesota Medicine Advisory Committee and editor of The Country Doctor.

WOMEN PHYSICIANS LEADING CHANGE

A panel discussion at the Minnesota Medical Association Annual Meeting by the MMA Committee on Women Physicians

*Thursday, September 28, 1995
4:30 p.m. to 6 p.m.*

Kabler Plaza Hotel, Rochester

For more information or to register, contact Jennifer Nelson at the MMA, 612/378-1875 or 800/999-1875

Look for this seal



The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBer), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this Seal. This Seal is your assurance that the product or service offered meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the  the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR... physicians working for physicians.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

People and Places Making Medical News

People

Swain Resigns from Health Care Commission

Tom Swain has resigned as chair of the Minnesota Health Care Commission, the group that advises the Legislature on how to control health care costs, how to provide health care coverage for those without insurance, and how to pay for such coverage. Swain was named chair of the commission in 1992, when it was formed under MinnesotaCare.

"I had lots of enthusiasm. I guess after three years, it's time for someone else to give it a try," said the 74-year-old retired executive of the St. Paul Companies in a *St. Paul Pioneer Press* article. He said he's been less enthusiastic about the job since tax-shy legislators rejected the commission's proposals for funding MinnesotaCare. In December, the commission recommended a 40-cent per-pack increase in the cigarette tax and a "freeloader penalty" for those who can afford health insurance but choose not to buy it. Both the governor and the Legislature rejected the proposals.

Swain said he is concerned that improving the health insurance system has "moved off the top priority list for the present," but the cost of health care and the aging population will cause the issue to surface again. In a letter to Carlson, Swain said that the 1995 legislative session has set the commission on a more "study-oriented" course, departing from its previous focus on accomplishing specific goals. "Given the change in emphasis, it's also time for change in leadership," he said.

Hart Resigns from UMHS

Greg Hart has resigned as president of the University of Minnesota Health System (UMHS). He will

join Larson Allen Weishair and Co., a Minneapolis-based consulting and accounting firm, in mid-September.

In his new role, Hart plans to help expand the company's health care consulting business, especially among academic institutions nationwide. While his new title is still undetermined, Hart said that his salary will be "roughly equivalent" to what he earned at the university, according to a *St. Paul Pioneer Press* article. He said he decided to leave the university because the new position was a good opportunity for him.

The university will not replace Hart for at least six to 12 months, and maybe not at all, according to Michael Dougherty, chair of UMHS's board of governors. The university is reorganizing under Provost William Brody, M.D., Ph.D., who assumed the position in May 1994.

Before he became president of the university health system in October 1993, Hart was general director from 1992 to 1993 and chief operating officer from 1981 to 1992. He's been an administrator with the hospital since 1975.

UMHS Board of Governors

R. Morton Bolman III, M.D., professor of surgery, has been appointed to the University of Minnesota Health System's board of governors. Bolman is chair of the division of cardiovascular and thoracic surgery at the university's department of surgery and is director of the Minnesota Heart and Lung Institute.

The board, which reports to the university's board of regents, consists of 22 community members, including one from each legislative district, and 10 members from within the university.

Children's Health Care Director

James Levin, M.D., Ph.D., has been appointed medical director of informatics for Children's Health Care—the first hospital system in the Twin Cities to appoint a physician as an informatician.

Levin has developed a system for the Children's Immunization Project, which tracks patients' immunization records and allows the hospital to measure its effectiveness at immunizing patients. Children's has begun to use the system, which eventually will also send reminders to parents when their children are due for shots.

Levin, a member of the Minnesota Department of Health Immunization Practices Task Force Registry Work Group, joined Children's-St. Paul in 1994 as a consultant in the pediatric infectious disease program.

New ADA Board Member

Richard M. Bergenstal, M.D., has been elected to the National Board of Directors of the American Diabetes Association (ADA) at its 55th Annual Meeting and Scientific Sessions in Atlanta. Bergenstal is chair of the Section of Endocrinology and an adult endocrinologist at Park Nicollett Clinic HealthSystem Minnesota and senior vice president of the International Diabetes Center. He is also clinical associate professor in the Department of Medicine at the University of Minnesota.

Bergenstal, who began volunteer activities for the Minnesota-affiliate ADA in 1988, served as president from 1992 to 1993. He continues to serve on the Board of Trustees for the Minnesota affiliate.

The American Diabetes Association, which was established in 1940 and has an office in every state, is the nation's leading voluntary health organization supporting diabetes research, information, and advocacy.

New Minneapolis Heart Institute Foundation President

Ford Watson Bell, D.V.M., was named president of the Minneapolis Heart Institute Foundation, effective August 1. He assumed the full-time position after 10 years as

a member of the organization's board of directors. Bell is co-founder of the Metropolitan Veterinary Referral Services and has served on many boards, including the James Bell Foundation and the James Ford Bell

Museum of Natural History at the University of Minnesota.

Before assuming his new position, Bell was clinical assistant professor, oncology, at the University of Minnesota's College of Veterinary Medicine.

The Minneapolis Heart Institute Foundation is an independent, nonprofit community-based research and education organization established in 1982 by the physicians of the Minneapolis Heart Institute. In addition to conducting numerous research studies, the foundation offers a wide range of community education programs in cardiac health for children and adults.

HealthEast Capitol Medical Laboratory offers solutions

Providing services to physician office laboratories, long term care facilities, home care agencies, group homes, and corporate health and wellness programs • Professionally staffed • Locally owned and operated • Open 24 hours, 7 days/week • Member HealthEast Community Based Services

Providing solutions
and expanded services
for your office. For more
information, contact
CMLMarketing at (612)

232-3246

HealthEast  Capitol

Medical Laboratory

69 West Exchange Street

St. Paul, MN 55102

Customer Service: (612) 232-3500

• Minnesotans serving Minnesotans •

P l a c e s

.....

State Housing Program Recognized

The AIDS/STD Prevention Services Section at the Minnesota Department of Health (MDH) received in July an achievement award from the U.S. Department of Housing and Urban Development for its efforts to address the housing needs of people living with AIDS or HIV. Fraser Nelson and Sonia Richardson received special recognition for their work on this project.

Earlier this year, the MDH and the Coalition for Housing for Persons with HIV collaboratively completed a five-year plan that focuses on housing issues for people with HIV. The plan calls for the creation of an HIV Housing Clearinghouse to provide information about housing options and to increase the availability of appropriate, affordable housing for people with HIV.

A survey conducted by MDH and the coalition found that 44 percent of Minnesotans with HIV had been homeless at some point, 43 percent occupied housing that did not meet their needs, 26 percent were on a waiting list for subsidized housing, and 10 percent were homeless. An estimated 3,000 people are currently living with HIV or AIDS in Minnesota.

Northwest Airlines Receives Community Service Award

Northwest Airlines, Inc., received the Dr. William O'Brien Community Service Award, which was presented by Memorial Blood Centers of Minnesota (MBCsM) at the centers' annual board meeting in July.

Northwest was recognized for its outstanding dedication to the community's blood supply through public service that included employee blood drives, promotional appearances, and public service announcements. Northwest Airlines held its first blood drive in 1954 and started sponsoring regular blood drives in the 1970s. For several years, Northwest Airlines employees have been the largest group of volunteer blood donors for MBCsM.

The Dr. William O'Brien Community Service Award was established in 1993 in memory of O'Brien, who died that year. O'Brien, who was an internal medicine physician, was a member of the Memorial Blood Centers' board of directors for 35 years.

The MBCsM is a nonprofit organization that operates Memorial Blood Center of Minneapolis and Arrowhead Regional Blood Center and supplies blood components and services to hospitals in Hennepin and Anoka counties, Duluth, and the Arrowhead region.

Socioeconomics

Minnesota Joins BHCAG

The state of Minnesota has joined the Business Health Care Action Group, a Twin Cities-based buying coalition. For the next two years, state employees will continue to choose from a variety of health plan options, but the state has committed to working with the BHCAG toward its new goal of eventually buying health care directly from clinics, hospitals, and physicians.

More than 60,000 state and University of Minnesota workers and their dependents are insured

under the state's programs. Minnesota is the largest single employer in the state.

Medtronic, Inc., has decided to leave the BHCAG because it is unhappy with the coalition's new purchasing philosophy. BHCAG

has been advocating that large buying groups like itself should buy directly from health care providers, such as clinics, hospitals, and physicians, rather than from large health plans.

The coalition also announced

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/board-eligible physicians:

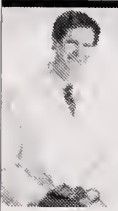
- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
612-885-6224
1-800-842-6469





"We found a quality of life in Eastern Washington that just can't be beat."

Wallace S. Gibbons, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a 55 year-old, multi-specialty group of 115+ physicians, has several practice opportunities throughout its practice locations. Currently, we are seeking:

WENATCHEE/EAST WENATCHEE

- Family Practice w/OB
- Ophthalmologist (w/retina)
- General Internist • Urgent Care

MOSES LAKE/OMAK

- Pediatrician • Orthoped
- Surgeon (General)
- Radiologist (General)

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807

FAX (509) 664-7178

CALL (509) 663-8711
ext. 5203



**Wenatchee
Valley
Clinic**

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.

Eight First Avenue South

Buffalo, MN 55313

Phone: 800-876-7171

or 800-295-6373

Fax: 682-4791

plans to change its name to Buyers Health Care Action Group.

Faribault Clinic Joining Allina

Allina Health System has agreed to buy the assets of the Faribault Clinic, which employs 14 full-time physicians. The clinic's name will remain the same, and the group will retain its relationships with other health care providers. The clinic will become part of Allina's group practice organization, which includes clinics in more than 50 locations in Minnesota and western Wisconsin.

"A large number of our patients work in the south metro area and have health care plans from the metro area, so we wanted to continue serving our patients by participating in Allina," said Ray Wood, Faribault Clinic president, in a Twin Cities *Star Tribune* article. The clinic plans to add two physicians to its staff after it finalizes the deal in September.

HealthPartners Forms Joint Venture With Quality Health Alliance

HealthPartners is forming a joint venture with Quality Health Alliance to establish a health plan that will serve Mankato and other areas in south-central Minnesota. Quality Health Alliance is a Mankato-based group of providers. The venture is significant because it is the first alliance to be formed between a Twin Cities-based health plan and a provider cooperative.

MedPower Inc., a Bloomington-based information processing firm, is also part of the joint venture. The groups will market a health plan to Twin Cities-area employers who have subsidiary operations in the Mankato area and to employees and individuals in the area. HealthPartners will provide administrative, marketing, and managed care expertise to the joint venture, said Executive Vice President Mary Brainerd in the *Star Tribune* article.

Ramsey County Drops HealthPartners

Ramsey County Commissioners voted to drop HealthPartners as a possible provider beginning January 1996 because of the health plan's high bid. HealthPartners proposed a 2.9 percent rate increase for 1996. Medica offered a 1.5 percent decrease and Blue Cross and Blue Shield of Minnesota a 2.3 percent increase. As *Minnesota Medicine* goes to press, the county's Labor Management Committee has recommended Medica. The commissioners will vote in late August. Once the decision is finalized, about 5,700 people will have to switch doctors.

HealthPartners was the county's sole health care insurer for the past 18 months, and for 23 years was among the insurance options available to the county's 7,300 employees, retirees, and their dependents.

Last December, Medica underbid HealthPartners to win a contract to provide care to 14,000 workers for small companies. Within the past 12 months, Medica has added 100,000 new members, while HealthPartners has added 30,000 members, according to Medica President David Strand.

Law and Policy

Psychiatrist Found Guilty in Repressed-Memory Trial

After deliberating for less than 10 hours, a Ramsey County jury ruled that St. Paul psychiatrist Diane Humenansky, M.D., was negligent in treating her patient, Vynnette Hamanne, who accused the psychiatrist of implanting in her mind false memories of strange childhood sexual abuse. The jury awarded Hamanne, of White Bear Lake, more than \$2 million for pain and suffering, lost earnings, and medical expenses up to the trial, and an additional \$461,000 for future damages. Her husband was awarded \$210,000 for loss of partnership.

The doctor allegedly told Hamanne that she had been

sexually abused by family members who belonged to a satanic cult and that her past abuse caused her to develop multiple personalities. She also told Hamanne that she could not remember her abuse because she suffered from repression, and that to be helped she would have to "recover" memories of the abuse.

Humenansky is involved in at least five other lawsuits alleging that she traumatized patients by making them recall false memories of childhood sexual abuse. Patients claim she used a coercive program that included mind-altering drugs, hypnosis, and threats; that she subjected them to anti-male and anti-Catholic diatribes; and that she was friendlier with them than professional guidelines allow.

The Minnesota Board of Medical Practice required Humenansky to undergo a physical and psychological exam earlier this year after questions were raised about her fitness to practice. Humenansky said she still holds her medical license.

Rates, Trends, Data

Mayo, 'U' Among Hospital Elite

The Mayo Clinic in Rochester, Minnesota, has been ranked No. 2 among the nation's 1,631 elite hospitals for reputation and performance in 16 medical specialties. Johns Hopkins Hospital in Baltimore is first, according to the *U.S. News & World Report's* 1995 edition of "America's Best Hospitals," which also lists the University of Minnesota among the top 128 hospitals in the country.

Mayo ranked first in gastroenterology, neurology, rheumatology, orthopedics, and endocrinology, and second in cardiology, urology, and gynecology.

The rankings were based on reputation, Medicare death-rate statistics, and such data as the ratios of medical specialists and nurses to hospital beds. The research group mailed questionnaires to 150 randomly selected specialists in 16 fields. Participants

were asked to list five hospitals they considered the best without taking location or expense into account.

The University of Minnesota received fewer high rankings than it has in the past. This year it ranked 27th in neurology and endocrinology, 30th in otolaryngology, 32nd in orthopedics, and 40th in urology. Last year the hospital was rated in the top 40 for expertise in nine specialties. Any institution listed among the top 40 medical centers in any specialty is considered a leading center, according to the magazine.

Tick-Borne Disease Diagnosed in Duluth

Six people were diagnosed near Duluth this year with the potentially lethal bacterial disease human granulocytic ehrlichiosis (HGE), believed to be transmitted by the tick that also carries Lyme disease. Three of the Duluth victims were from northeastern Minnesota,

and three were from northern Wisconsin.

Since 1990, 47 people have been diagnosed with HGE at the Duluth Clinic, said Johan Bakken, M.D., the clinic's infectious disease specialist, in a Twin Cities *Star Tribune* article. Other cases have been diagnosed in Minnesota and Wisconsin. "Four patients [in this region] are dead, two from our series [of 47], and two who were seen by other physicians," said Bakken.

Symptoms associated with HGE include fever, headache, muscle ache, and chills. Less frequent symptoms include nausea, vomiting, loss of appetite, cough, and aching joints. HGE responds to the antibiotics tetracycline and doxycycline; however, it does not respond to the antibiotics usually prescribed for Lyme disease, said Bakken.

"We are pretty sure the deer tick is a [carrier] for this, and we suspect that wood ticks also can

Occupational Medicine

St. Luke's Hospital in Duluth, MN, is seeking an additional physician for our Occupational Medicine Clinic. Full-time position with ideal hours and comprehensive salary/benefit package. No on-call requirements. Occasional cross-coverage in our adjacent Urgent Care Clinic.

For more information, contact:

Linda Basara

St. Luke's Hospital
915 East First Street
Duluth, MN 55805
1-800-321-3790

St. Luke's
HOSPITAL OF DULUTH

transmit it," Bakken said. Forty-five percent of the patients from Minnesota and Wisconsin say they had a deer-tick bite, 33 percent say they were bitten by wood ticks, and the rest don't recall being bitten.

The total number of cases of HGE is uncertain because the state does not require health care professionals to report HGE to the Minnesota Department of Health, said Craig Hedberg, a Health Department epidemiologist, in the same *Star Tribune* article.

Medical Research

Twin Cities To Study Foodborne Diseases

The Twin Cities metro area is one of five sites selected to participate in a new joint state-federal effort to collect data that will help scientists better understand foodborne diseases that cause diarrhea.

Federal officials say they hope to learn more about how many Americans suffer from foodborne diseases, which are thought to be responsible for approximately 6 million to 33 million illnesses and possibly thousands of deaths each year. State health officials, in collaboration with the national Centers for Disease Control and Prevention, will focus on tracing cases of the deadliest bacterial strains, *E. coli* 0157:H7 and *salmonella* species, and identifying new pathogens that cause illness.

The project, which is a part of a broad federal effort to prevent widespread outbreaks of food poisoning as global food supplies reach larger populations, is intended to identify risk of diseases associated with dairy products, fruits, vegetables, and seafoods regulated by the Food and Drug Administration, as well as meat, poultry, and eggs regulated by the U.S. Department of Agriculture. These agencies and the CDC will fund the \$1 million, six-month start-up of the project, and may continue the funding for years.

'U' Study Says Fatty Diets Increase Breast Cancer

New evidence shows that diets high in fat increase a woman's risk of dying of breast cancer, according to University of Minnesota researchers.

A study of 698 postmenopausal Iowa women with breast cancer found that the death rate from breast cancer within an average of three years of diagnosis was twice as high for women with the highest fat consumption as among those with the lowest fat consumption. In addition, the death rate for obese women was 60 percent higher than among non-obese women. And women with diets high in animal fat and who were most obese had the highest death rate among the 8 percent who died within three years of diagnosis, according to the study, published in the July 15 issue of *Cancer*.

Study participants were chosen from 41,800 randomly selected Iowa women aged 55 to 69 who filled out questionnaires in 1986 on smoking history, family history of cancer, breast cancer risk factors, physical measurements, and dietary choices. Women subsequently diagnosed with breast cancer, identified by computer from the State Health Registry of Iowa, were treated from 1986 through 1991, and their conditions were monitored for an average of three years.

Death rates were highest among women with the following risk factors: older age, cancer that had spread, larger tumors, a close relative with breast cancer, a higher education level, and a history of cigarette smoking. Researchers found no evidence of longer survival among women who consumed large amounts of dietary fiber, beta-carotene, or vitamins A, C, or E.

Although the research doesn't show that obesity or high-fat diets cause breast cancer, evidence strongly suggests that obesity and high consumption of animal fat may encourage the spread of cancer. "It seems prudent for women to consider limiting excess

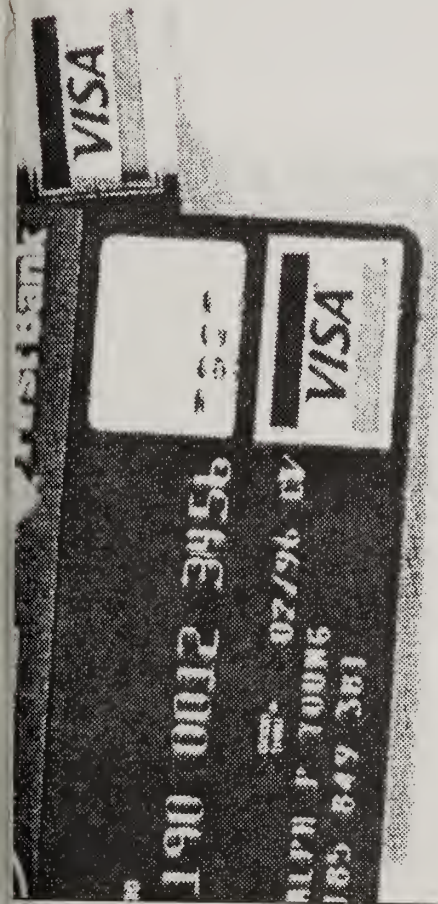
fat to potentially improve breast cancer prognosis," at least until a more definitive study is concluded, said Aaron Folsom, M.D., associate professor of epidemiology and a lead researcher of the study.

TB Outbreak Traced to Minneapolis Bar

Minnesota researchers reported in the July 27 *New England Journal of Medicine* a 1992 outbreak of tuberculosis caused by a 48-year-old homeless man who frequented a Minneapolis bar. The man, who developed a severe case of tuberculosis, apparently spread the infection to 41 of 97 regular customers in October 1992.

After interviewing the 97 regular bar customers and administering tests to several, researchers found that 14 of the 41 infected individuals had active cases of the disease. Four other bar patrons not involved in the original screening subsequently developed active cases of tuberculosis. One bar patron died within two weeks of diagnosis, but doctors managed to successfully treat all the others with active cases of the disease, including the original carrier. Researchers noted that in 1994, a 7-month-old child and a 36-year-old man who had had no contact with the bar developed active cases of the disease after exposure to bar patrons with active TB.

Outbreaks of tuberculosis in public places are not unusual in other parts of the country, but the high disease rate in this case—42 percent of the bar's patrons became infected and 14 percent developed active cases—was unusual. Normally in such outbreaks, 20 percent to 30 percent of individuals exposed would become infected, and only 1 percent to 2 percent would develop active cases. The researchers believe the high incidence may be related to the strong infection in the original carrier and to the bar patrons' heavy alcohol use, which weakens immunity. MM



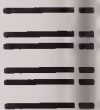
**Yes! Please send me a First Bank
WorldPerks® Visa® application.**

Name _____

Street Address _____

City, State, Zip _____





NO POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.*
Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)

995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

WE ARE PLEASED TO ANNOUNCE

Robert G. Jacoby, M.D. &
Debra L. Peven, D.O.

HAVE JOINED OUR PRACTICE.



Robert Jacoby, M.D. Debra Peven, D.O.

Doctor Jacoby received his medical degree from Washington University at St. Louis. He completed his residency and was Chief Resident at the University of Iowa. He continued at Iowa doing a Clinical Neurology Fellowship and became Co-director of the University of Iowa Neurology Clinic.

Doctor Jacoby is board certified in neurology with special interests in headache management, movement disorders and demyelinating diseases.

Doctor Jacoby will primarily practice at the Unity Professional Building in Fridley.

Doctor Peven received her medical degree from the Michigan State University College of Osteopathic Medicine. She completed her residency in neurology and a fellowship in neuromuscular diseases and EMG at Henry Ford Hospital in Detroit, Michigan.

Doctor Peven is board certified in neurology, and in electromyography. She has a special interest in neuromuscular diseases, sports medicine and in the neurologic complications of AIDS.

Doctor Peven will primarily practice at the Unity Professional Building in Fridley.

The Noran Neurological Clinic, P.A. specializes in adult and pediatric neurology and neuropsychology.

**NORAN NEUROLOGICAL
CLINIC, P.A.**

786-8406

MURRAY

(continued from page 7)

Cass Lake, Minnesota, from 1977 to 1978. He returned to Mayo as a resident in 1979. He briefly trained at LDS Hospital in Salt Lake City, Utah, taught at Texas Tech Medical School, and then returned to Mayo on a fellowship in 1983. Murray has served as a Mayo consultant (clinic speak for staff member) since 1986 and was an assistant professor from 1986 to 1994 and is now an associate professor at Mayo Graduate School of Medicine. He is a lieutenant colonel in the U.S. Army Reserve Medical Corps and has served as the chief of professional services at the U.S. 114th Combat Support Hospital at Fort Snelling since 1994.

Murray and his wife, Catherine Friederich, have a home in the wooded hills of southwest Rochester, where they are busy raising their four children, ages 13, 11, 9, and 6. Friederich is a free-lance editor specializing in health care topics. The couple recently celebrated their 15th wedding an-

niversary with a trip to Portugal.

Crisscrossing Minnesota as the MMA's president won't mean a more hectic lifestyle for Murray. Instead, he'll likely spend more time closer to home. Murray's research expertise in various areas of anesthesiology has put him in demand as a lecturer at medical centers around the world, but this year he says he'll accept fewer lecture engagements. "Instead of going to Europe or Asia, I'll reserve my time for Minnesota," he says.

Murray is one of a handful of anesthesiologists in the United States who specialize in nutrition. His current research involves the use of several types of fatty acids as nutrients in critically ill patients. Other research areas include clinical studies of patients undergoing anesthesia for vascular operations. His expertise sent him to three countries just last year as a lecturer, and he's been a visiting professor at numerous clinics and universities in the United States.

The tasks ahead of him will be challenging, Murray acknowledges. Health care system reform is a complicated topic, and choices made by state and national leaders aren't always well received, he says. With the world perspective from his travels abroad, Murray believes he can both understand why changes must be made and why those decisions are difficult to accept.

"The costs have gone up, and as a society we can't compete with these kinds of costs in a global economy, [yet] I don't think people in the U.S. are willing to sacrifice personal care for the good of society," he says.

Murray, nevertheless, is confident American health care can reach a compromise between rising costs and rising expectations. In addition, he is certain physicians will play a critical role in maintaining quality care, but he believes physicians must work together under the umbrella of the Minnesota Medical Association. Patients also must be included, he says, because they ultimately will feel the changes. "Everyone must be involved in the process," he says. "That's the key."

MM

J. P. Miller is a free-lance writer covering the greater Twin Cities area.

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Urgent Care
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

M MULTICARE • ASSOCIATES
OF • THE • TWIN • CITIES

GUNSHOT WOUNDS

(continued from page 32)

months of Massachusetts' experience, the system logged 451 GSW and 894 sharp instrument wounds (SIW). Based on these findings, the annual rate of GSW for Massachusetts rises from a previously reported average of 4.6/100,000 (F-GSW only)¹² to an estimated 15/100,000 for 1994 (fatal and nonfatal). The SIW estimate is an even higher 30. The Massachusetts data dramatically show the impact accurate data can have on the reported prevalence rate of GSW and other violence-related injury.

Collecting GSW data can be problematic. Periodic audits of the Massachusetts system have indicated the following GSW data are missing: 25% of demographic variables; 32% to 68% of victim/offender relationships; and 26% to 57% of the precipitating circumstances. Presumably, this is due in part to the elusive and often criminal nature of many GSWs. In Minnesota, an average of 37% of gun-related assaults remain unsolved.⁹

The missing GSW data from the Massachusetts experience appear to be information likely collected by police reports. It seems reasonable that collection of a more complete data set can be achieved through the coordinated efforts of medical personnel and police. This was the original intent of Minnesota's Suspicious Wounds Reporting Law. By using modern telecommunication and a computer network, an integrated suspicious wounds reporting system could be developed to interface with Minnesota's medical personnel and the local police to provide important GSW data, as well as data on the violence-related injuries of sharp instrument wounds and blunt assault wounds. A single agency must be assigned to collect and report these data.

The systematic collection of data on fatal and nonfatal violence-related injuries is essential to developing a scientific-based approach to preventing these injuries. It can also assist in creating legislation and public education designed to reduce the risk of such injuries, as well as to identify groups and communities at highest

risk for such injuries and evaluate preventive procedures. **MM**

Acknowledgment

Our thanks to the survey participants who cooperatively provided GSW data. Special thanks to Audrey Boyle and Marsha Zimmermann of Hennepin County Medical Center, Peg Fox of St. Paul-Ramsey Medical Center, and Ann Fox of North Memorial Medical Center.

Gary Riestenberg is a family researcher and writer. He is currently interning at East Side Neighborhood Services in Minneapolis as a family therapist serving family members who have been arrested for domestic abuse. Douglas Brunette is an emergency medicine physician at Hennepin County Medical Center in Minneapolis and residency director for the Department of Emergency Medicine Residency Program.

REFERENCES

1. Billings J, Teicholz N. The cost of criminal violence in the District of Columbia hospitals. Washington D.C.: District of Columbia Hospital Association, 1991.
2. Lee LK, Waxweiler RJ, Dobbins JG, Paschetag T. Incidence rates of firearm injuries in Galveston, Texas, 1979-81. *Am J Epidemiol* 1991;134(5):511-21.
3. Payne JE, Berne TV, Kaufman RL, Dubrowskij R. Outcome of treatment of 686 GSW of the trunk at Los Angeles County-USC Medical Center: implications for the community. *J Trauma* 1993;34(2):276-81.
4. Kizer KW, Vassar MJ, Harry RI, Layton KD. Hospitalization charges, costs and income from firearm-related injuries at a university trauma center. *JAMA* 1995; 273(22):1768-73.
5. Brunette D. Going after guns. *Minn Med* 1994;77(3):25-7.
6. Minnesota Medical Association Firearm Injury Prevention Task Force. Firearm Mortality in Minnesota. *Minn Med* 1994;77(3):22-4.
7. A deadly beginning: a midyear high for homicides. *Minneapolis Star Tribune* 1995 July 9;Sect.A:16.
8. U.S. Department of Health and Human Services. International code of diseases. 9th ed. (ICD-9). Hyattsville, Maryland: Department of Health and Human Services, 1991. # (PHS) 91-1260.
9. Minnesota crime information reports (1991-1994). St. Paul, Minnesota: Minnesota Department of Public Safety.
10. U.S. Bureau of the Census. Statistical abstract of the United States. 114th ed.

Washington, D.C.: Government Printing Office, 1994.

11. Minnesota Department of Health. Minnesota hospital statistics. St. Paul, Minnesota: Division of Facility and Provider Compliance, Minnesota Department of Health, 1993.
12. National Center for Health Statistics. Injury mortality atlas of the United States: Atlanta: Biometrics Branch, Centers for Disease Control and Prevention, 1991.
13. Tardiff K, Marzuk PM, Leon AC, et al. Homicide in New York. *JAMA* 1994; 272(1):43-6.
14. Cotton P. Gun-associated violence increasingly viewed as public health challenge. *JAMA* 1992;267(9):1171-4.
15. Minnesota Center for Health Statistics. Minnesota resident death by sex and age by single cause of death, 1991-1993. [Unpublished tables]. Minneapolis: Minnesota Department of Health.
16. Teret SP, Wintemute GJ, Beilenson PL. The firearm fatality reporting system: a proposal. *JAMA* 1992;267(22):3073-4.
17. Remington PL, Chudy NE, Nashold R. The Wisconsin firearm injury surveillance system. *Wis Med J* 1993(10):531-3.
18. Ozonoff V, Barber C, Hume B, Jannelli L, Schuster M, McLaughlin H. Emergency department surveillance for weapon-related injuries—Massachusetts, November 1993-April 1994. *MMWR* 1995;44(9):160-3.



PERSPECTIVES IN NUTRITION THERAPY

**THURSDAY
OCTOBER 5, 1995
MALL OF AMERICA GRAND HOTEL
Ballroom
5:30pm - 9:15pm**

Pierre Malek, MD FACP
Medical Director, F.H.P.
"The Medical Rationale
For A Balanced Diet"

Robert Pritikin
Director of the Pritikin Longevity Center
"The Fat Instinct—
How To Outsmart It"

To register or
for information, coll: **(612) 559-3211**

RDC concept

WOMEN PHYSICIANS

(continued from page 9)

and must contend with more paperwork and other administrative duties.

Female doctors may work less than male doctors for the same reasons other women control their work hours. Two-thirds of practicing women physicians have children. And although they have challenged many traditional roles, women remain the family caretakers.

Women physicians work fewer hours, on average, because of the time-consuming nature of family responsibilities, says Janet Bickel of the Association of American Medical Colleges. "The hourly gap will probably always be true as long as women are the primary caretakers of the family."

In one study of full-time pediatricians, the men performed 19 percent

of their family's child care and 26 percent of household duties. Women pediatricians took charge of 66 percent of child care and 63 percent of household duties.

Another reason for the lower incomes of female doctors is their tendency to choose lower-paying specialties, such as internal medicine, pediatrics, and family practice. Specialists, such as radiologists, surgeons, and cardiologists, typically earn more money than do these primary care practitioners. Women were 54 percent of residents in pediatrics in 1990, according to the AMA. But they were just 5 percent of residents in vascular surgery, one of the best-paying medical subspecialties.

"Women have always gone mainly into primary care," says Lila A. Wallis, M.D., a Manhattan internist and past president of the American Medical Women's Association. Schaller is more blunt: "Women have been pushed into primary care. They aren't always encouraged to go into the high-tech specialties."

Judith Lorber, author of "Women Physicians: Careers, Status and Power," predicts that as more women enter medicine, the profession will become increasingly stratified. The areas women dominate will become even less lucrative, she says. This already seems to be happening in obstetrics and gynecology.

There is some evidence that female physicians may not value a high salary as much as men do. "Ask men why they're entering medicine and they say 'prestige and salary.' Ask women why they're entering medicine, and they say 'helping people,'" says Bickel, citing surveys of medical school applicants.

Such altruism may benefit patients and taxpayers, but it may be a raw deal for female physicians. Lorber says that medicine in the United States already has a higher-paying end dominated by men and a lower-paying end dominated by women.

"The structure is a two-tiered one, very similar to what you have in Europe. Women are in pediatrics, obstetrics, and gynecology. Men are in hospital practices and super-specialties."

Schaller points out that in

Russia, medicine is a low-status and low-paid profession. Coincidentally or not, it is also one dominated by women.

The AMA predicts that women will make up one-third of the profession by 2010. As increasing numbers of women enter medicine, the fairness of a system that pays women less than men may inspire women to work to change the profession. To do so, women physicians must gain power, something relatively few women in medicine have achieved.

Women hold relatively few prestigious positions in medical education. In 1992 the American Association of Medical Colleges reported that women chaired only about 3 percent of medical school departments. Women are also less likely than men to move on to the tenure track of academic institutions, the conventional route to advancement.

The future role of women in medicine also depends on the choices women make concerning their professional lives.

Will women doctors continue to work at salaried jobs after their children are grown? Will they become more involved with their work and begin their own practices? Or will they embrace a less stressful professional life that requires fewer work hours and more time for other pursuits?

The decisions they make will affect the lives of their families, their patients, and the entire health care system.

MM

Patricia Braus is a contributing editor of *American Demographics*.

Reprinted with permission from *American Demographics*, November 1994. © 1994 American Demographics Inc.

ASPEN
Medical Group

**Family Practice
Internal Medicine**

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 160 professionals who offer care at 13 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

SEPTEMBER 1995

Sept. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Mental Health Issues for Primary Care Physicians** Allina Health System; Hotel Sofitel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12 **Molecular Biology for Colon and Rectal Surgery** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 12 **Promoting Successful Breastfeeding Through Community Collaboration** Naeve Health Care, Mayo Health System, and Freeborn County Public Health; Albert Lea, MN. CONTACT: Jane Madson, Naeve Health Care Association, 404 Fountain Street, Albert Lea, MN 56007; 612/373-2384.

Sept. 14-17 **Mechanical Ventilation: Principles and Applications** University of Minnesota Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 16 **Endorectal Ultrasonography** University of Minnesota Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 21-22 **Nineteenth Annual Scientific Symposium of the Midwest Pediatric Cardiology Society** Children's Heart Clinic; Children's Health Care-Minneapolis, MN. CONTACT: Denise Zang, The Children's Heart Clinic, Abbott Northwestern Medical Office Building, 2545 Chicago Avenue South, Suite 106, Minneapolis, MN 55404; 612/871-4660.

Sept. 22-23 **Nursing Home Medical Directors** University of Minnesota Continuing Medical Education; Sheraton Midway, St. Paul, MN. CONTACT: Registrar, Office of Con-

tinuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 28-29 **1995 Duluth Oncology Conference** Duluth Clinic; Fitger's Theatre of the North, Fitger's Complex, Duluth, MN. CONTACT: Rockie Odberg, Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Sept. 28-30 **Animal Models of Cardiac Dysfunction** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 29-30 **Recent Developments in Epilepsy and Neurology** Allina Health System and Minnesota Epilepsy Group; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

SEPTEMBER 1995

Sept. 22-23 **The Child With Unusual Infections** University of Minnesota Continuing Medical Education; Park Inn, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

OCTOBER 1995

Oct. 7 **Surgical Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

ENDURING MATERIALS

Videotape **Bloodborne Pathogens** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

OCTOBER 1995

Oct. 5-7 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 6-7 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 6-7 **Front Line Neurology** Allina Health System; Marquette Hotel, Minneapolis, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 7 **Orthopedic Symposium** Allina Health System; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-15 **Radiology '95: General Radiology Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis MN 55414; 612/626-7600.

Oct. 13 **Insights and Outlooks** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 13 **Ophthalmic Plastics Course** Phillips Eye Institute and Allina Health System; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14 **Current Trends in Ophthalmology** Phillips Eye Institute and Allina Health System; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 18-20 **Thirteenth Biennial Great Lakes Regional Conference: Prevention Strategies for Cardiovascular Disease** Department of Health, NHLBI, and Mayo Clinic; Mayo Medical Center, Rochester, MN. CONTACT: Kari Ptacek, Section of Continuing Medical Education, Mayo Foundation, 200 First Street SW, Rochester, MN 55905; 507/284-2085.

Oct. 18-20 **Internal Medicine Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

General Internist Opportunities

ReadyCare – Ramsey Clinic's urgent care facility, ReadyCare, offers patients convenient walk-in services and is supported by a comprehensive nurse triage system. A position is available for a general internist interested in working 20 hours per week or more. The position involves same day care and is flexible to include weekday or weekend hours, as well as possible additional hours in the Ramsey Clinic.

Health Center for Women – Our expanding Health Center for Women, a clinic focused on primary care for women from adolescence through geriatrics, has full and part-time staff positions available for internists with expertise in women's health. These positions involve one evening clinic – some hospital attending is preferred, but not required.

Ramsey Clinic – General internist opportunities are also available with the Ramsey Clinic or in combination with ReadyCare or Health Center for Women.

Board certified internists, forward your CV, including position preference (ReadyCare/Health Center for Women/Ramsey Clinic) to: **Sandy Lachman, Physician Services, Ramsey Clinic, 640 Jackson Street, St. Paul, MN 55101. Or fax your CV to (612) 221-8571. EOE.**



HealthPartners
Ramsey Clinic



You'll be glad you found Monroe

Our safe, family-centered community of 10,000 is just one hour from Madison, WI, Dubuque, IA and Rockford, IL...two hours from Chicago and Milwaukee...and number 23 in *100 Best Small Towns in America*. But the 50+ physicians in our multispecialty group practice rank Monroe number one. That's because of the town's friendly spirit, four-season climate, abundant recreational, educational and cultural amenities, relaxed pace, and the exciting professional opportunities at The Monroe Clinic—a consolidated, integrated healthcare facility including a new 114,000-sq.-ft. clinic and an adjoining 140-bed acute care hospital with 24-hour ER coverage serving south central WI and northern IL. We have openings for BC/BE physicians in: INTERNAL MEDICINE, FAMILY PRACTICE, EMERGENCY MEDICINE AND DERMATOLOGY at our main clinic and two of our seven branch locations.

We offer productivity based pay with excellent 1st year income guarantee, freedom from office management and buy-in costs, and comprehensive benefits including \$3750 CME allowance. For more information, write or call: **Physician Staffing Specialist, THE MONROE CLINIC, 515 22nd Ave., Monroe, WI 53566. 800-373-2564. Or fax resume to: 608/328-8269. EOE.**



The Monroe Clinic
A proud caring tradition

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., September 15 for November ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441. (*7/95-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine, (oncology, pulmonology, and nephrology), family practice, ophthalmology, and ob/gyn. Excellent salary/benefits package includes guaranteed salary the first year with full partnership after one year; health, dental, and life insurance; pension/profit sharing; and relocation assistance. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

EXCEPTIONAL OPPORTUNITY

at BlueCross BlueShield of Nebraska:

We have an opening for a Chief Medical Officer, preferably with an internal medicine or family practice background, to help develop and shape our corporate medical policies. Interested candidates should see themselves as leaders, capable of interacting with our medical community as well as business leaders. We're looking for a physician with vision, business savvy, extensive knowledge of current medical issues, and a lot of energy. Candidates must be licensed to practice medicine in the state of Nebraska (or be able to meet the requirements to obtain a license in Nebraska). Managed Care Certification and/or experience is highly desirable. Contact Micki Baldino, Sr. Vice President, Human Resources, in Omaha, Nebraska, 402-390-1813.

We are an equal opportunity employer M/F.



BlueCross BlueShield
of Nebraska

Escape From the Ordinary! Needed! General surgeon to work in our thriving rural family practice. Candidate should have skills in C-section, gynecology and laparoscopic surgery. Eight weeks' vacation/CME. Consultants available. Only group in county with three referral centers one hour away. Uniquely situated on I-94 halfway between Madison and the Twin Cities. Small-town pride, excellent 51-bed hospital, great schools and recreation including all water sports, hunting, fishing, cross country and downhill skiing. Cohesive group of caring physicians! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd., 610 West Adams Street, Black River Falls, WI 54615; 715/284-4311. (*9/95-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
612 • 763 • 5123



COASTAL
PHYSICIAN SERVICES
OF THE MIDWEST, INC.

Your Private Practice Alternative in the State of Minnesota



- No on-call
- Medical Directorships
- Assured Income
- Group Practice

Brian Nunning
800-326-2782 • FAX: 314-291-5152
3221 McKelvey, Suite 106, St. Louis, MO 63044

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: family medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates nine branch offices in southeastern Minnesota and staffs affiliate hospital emergency room. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (9/95-R)

Mankato, Minnesota: FP needed to join group of three board-certified family physicians and newly added part-time nurse practitioner and physician assistant in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Ski Steamboat Colorado: Three bedroom, three bath, non-smoking condo. Physician-owned. Sleeps eight. Washer/dryer, fireplace, heated garage, pool, sauna, hot tubs, cable TV, VCR, compact disc stereo. Free shuttles to lifts and town. Saturday to Saturday rentals, 612/427-8510.

*2-10/95



Columbia Park Medical Group

- Family Practice ● Internal Medicine
- Occupational Medicine ● Pediatrics
- BC/BE Specialists

FAMILY PRACTICE: Join group or do Urgent Care with a 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Nine-member department has busy hospital and clinic practice.

OCCUPATIONAL MEDICINE: Three B.C. physicians looking for additional physician to join busy Occupational Health Department.

PEDIATRICS: Seeking fourth pediatrician interested in primary and consultative pediatrics.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Tom Behrend, (612) 586-5882

GENERAL SURGEON — BE/BC —

The Department of Surgery at the Mayo Clinic, in conjunction with the Fairmont Clinic, is seeking two broad-based general surgeons to join a Mayo Regional Facility in Fairmont, Minnesota, 120 miles west of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 15-person Mayo-affiliated medical clinic in this town of about 11,000 with a 77-bed hospital and a service population of 45,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise, and excellent salary and benefits. Inquiries:

Michael G. Sarr, M.D.
Department of Surgery
Mayo Clinic
Rochester, MN 55905

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

EMERGENCY MEDICINE P • S • I • T • I • O • N • S

IOWA

NORTH & CENTRAL MINNESOTA

- Full- and part-time
- Comprehensive benefit packages
- Paid malpractice
- Professional environments
- Ample time for family and leisure
- Progressive physician-owned group
- Excellent compensation packages
- Various locations
- Reasonable housing in safe communities
- Top-notch school systems
- Quality lifestyles

CALL 1-800 458-5003

Emergency Practice Associates
or send CV to Sheila Jorgensen
P.O. Box 1260, Waterloo, IA 50704

Physician (Internist)

The St. Cloud, Minnesota, VA Medical Center is a dynamic 556-bed facility providing excellent psychiatric and intermediate care to veterans.

An exceptional opportunity exists for a physician board eligible or board certified in Internal Medicine with an interest in doing primary care and general internal medicine consultations. We offer competitive salary and benefits combined with a stable 40-hour weekly schedule.

To explore this unique opportunity, call or write:

Thomas Plombon, Human Resources Management Service 612-255-6301 or
Dr. Susan Markstrom, Chief, Medical Service
612-255-6371
VA Medical Center
4801 N. 8th Street
St. Cloud, MN 56303

Primary Care Physicians for weeknight, weekend, and holiday coverage at medical center in Rochester. Current BCLS and ACLS required; licensure from any state acceptable. Residents encouraged to apply. We offer flexible schedules and malpractice coverage. Contact in confidence Annashae Corporation, Professional Healthcare Staffing, 800/245-2662. *2-10/95

Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, and Locum Tenens opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Enjoy culture, academics, and shopping plus the four seasons in the land of 10,000 lakes. Contact Allina Physicians Services, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 800/248-4921. *3-9/95

Family Physician to join the medical staff of five family practitioners in a well-established, growing clinic in central Minnesota, along the southern shores of beautiful Mille Lacs lake. Work in two newly constructed, modern clinics; one is attached to the hospital. Excellent subspecialty support, progressive community hospital, diverse patient population. Guaranteed salary with incentive plan and a broad range of benefits. Call collect, 612/532-3154, or write to Frederick W. Haack, Administrator/CEO, Mille Lacs Health System, PO Box A, Onamia, MN 56359. *6-9/95

Emergency Room Physician

Community hospital, thirty minutes from a Big-10 university, seeks full-time emergency room physician to join two full-time ER physicians in expanding services. Must be BC/BE in family practice or other primary care field. Certification in ACLS/ATLS/PALS required. Our candidate must be interested in teaching, community involvement, and willing to make a commitment in a beautiful geographical area that offers year-round recreation plus numerous opportunities for professional, educational and cultural growth and involvement. Excellent salary and benefit package with a financially strong and visionary 36-bed community hospital with an expanding, young primary care and specialty medical staff. For confidential consideration, please send resume to: Minnesota Medical Association, Box 860, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761.

AIM HIGH

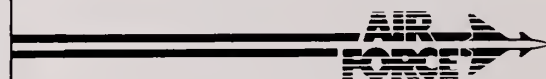
**CREATE A
MEDICAL
BREAKTHROUGH.**

Become an Air Force physician and find the career breakthrough you've been looking for.

- No office overhead
- Dedicated, professional staff
- Quality lifestyle, quality practice
- 30 days vacation with pay per year

Today's Air Force provides medical breakthroughs. Call

**USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF**



Central Plains Clinic, Ltd., is seeking BC/BE physicians in the following specialties: cardiology, orthopedic surgery, physiatry, and radiology. Central Plains Clinic, Ltd., is an 88-physician multispecialty practice located in Sioux Falls, South Dakota. Excellent benefits package with a competitive first-year salary guarantee. For more information, send CV or call David Rossing, M.D., Medical Director, Central Plains Clinic, Ltd., 1100 East 21st Street, Sioux Falls, SD 57105; 605/331-3490, or fax: 605/330-6555.

*1-9/95

Family Medicine: Loving your job is no longer a myth! Opportunities are now available for family physicians who believe that professional satisfaction and personal happiness are equally important. A prominent 300-plus physician-owned group based in southwestern Wisconsin has practice opportunities available at established clinics in Iowa and Wisconsin. Exceptional call coverage results in more time to savor the breathtaking river communities, rolling hills, and woodlands. If outdoor activities, cultural amenities, and a superior practice environment are important to you, please call Susan Pierce at 800/243-4353.

*1-9/95

Older M.D. seeks private practice in Minnesota, North Dakota, or Wisconsin. Write MED Professionals, Box 201801, Bloomington, MN 55420.

*1-9/95

NURSES!

**ENHANCE YOUR CAREER ★ BECOME A NAVAL RESERVE NURSE
\$9,000-\$30,000 BONUSES**

Motivated nurses around the United States are enhancing their leadership skills by joining the Naval Reserve Health Care Team. Through this flexible, part-time opportunity you can experience the pride and prestige of being a Naval officer. Serve your country with other medical professionals while you receive training in military medicine. If qualified, you may be eligible



You and the Naval Reserve.
Full Speed Ahead.

for a \$3,000 to \$10,000 yearly bonus for three years in addition to a competitive pay and retirement package. Other benefits include financial assistance for advanced nursing education, worldwide travel opportunities, shopping at military stores, and full-time term life insurance.

If you would like to know more about wearing the gold of a Naval Reserve nurse, call:

1-800-633-3209

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Family Practitioner • Internist

**Want the best of
BOTH worlds?**

Live and work in a rural community—yet have easy access to the educational, cultural, shopping, and entertainment opportunities of the big city. Enjoy all the benefits that go with small-town living—good neighbors, safe schools, affordable housing, abundant recreational choices—and go to the city when you want!

St. Croix Falls, Wisconsin is located just over the scenic St. Croix River from Taylors Falls, Minnesota and within 45 minutes of the metropolitan Twin Cities. With 25,000 households within the clinic service area, River Valley Medical Center is the region's largest and most diversified practice group—13 family practitioners, 2 internists, 2 general surgeons, 2 orthopedic surgeons and a physician assistant. Clinic is attached to a 50-bed acute care hospital with a wide range of services.

Guaranteed first-year salary with second-year partnership and excellent fringes.



Send detailed CV to:
Cathy Kortas
River Valley Medical Center
208 S. Adams St.
St. Croix Falls, WI 54024

Internist...

Want to share call with 8 other Internists and live in the Brainerd lakes area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30-physician independent multi-specialty group
- Located in a primary service area of 40,000
- Almost 100% fee-for-service
- Excellent fringe benefits
- Compensation at least what the market pays
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Inquiries from Internists with subspecialty interest in Pulmonology and Rheumatology welcomed.

Call collect to administrator:

- Curt Nielsen
218-828-7105 or
218-829-4901
2024 South 6th Street
Brainerd, MN 56401



Emergency Medicine—Texas: Tired of the long winters and high taxes? Come to Corsicana, a Midwestern-like town of 23,000 near Dallas. ED at 24,000-plus volume has immediate full-time opening. Twelve to 15 shifts/month. Candidates will be BC/BE in emergency medicine. Productivity-based compensation at \$90 to \$120-plus an hour! Fast track and continuity clinic. Enjoy low cost of living, good schools, no state income tax, and plenty of recreational options. Contact Rebecca Turley, 800/338-7107; fax: 414/785-0895. *1-9/95

SEPTEMBER 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	64
Aspen Medical Group	60
Audio Digital Foundation	19
Blue Cross and Blue Shield	64
Brainerd Medical Center	68
Central Minnesota Group Health Plan	28
C.F. Anderson Co., Inc.	23
Chisago Health Services	23
Coastal Physicians	64
Columbia Park Medical Group	65
Emergency Practice Associates	65
Fairview Clinic Services	53
Gillette Children's Hospital	28
HealthEast	Cover 4
HealthEast Capitol Medical Laboratory	52
HealthPartners	4, 23, 47, 62
Hennepin Faculty Associates	3
Mayo Foundation	65
Medical Protective Company	42
Minnesota Medical Business Resources	Cover 3, 50, 57
Minnesota Physicians Insurance Agency	41
MMA Peer Review Consultation Services	48
Monroe Clinic	62
Moonlight Home Health Care	67
Multicare Associates of the Twin Cities	58
Navy Reserve Recruitment	67
Noran Neurological Clinic	58
Norwest Bank	46
North Memorial Medical Center	4
NSP	Cover 2
Oxboro Clinics	47
Pritikin Malek Conference	59
River Valley Medical Center	67
St. Francis, Inc.	68
St. Luke's Hospital	55
St. Paul-Ramsey CME	24
Sauk Prairie Memorial Hospital	66
State Farm Insurance	24
THC Minneapolis	47
U.S. Air Force Health Professionals	66
Veterans Affairs Medical Center—Minneapolis	24
Veterans Affairs Medical Center—St. Cloud	66
Wenatchee Valley Clinic	54
Whitesell Medical Locums, Ltd.	54

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare system

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine
Internal Medicine
Orthopedic Surgery
Noninvasive Cardiology
Neurology
Pediatrics

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-3745.

Reasons you should **not** attend AMA's October 28 Innovative Financial Strategies Seminar:



- 1** You know your financial plan is so complete that you are not at all concerned about taxes, inflation or retirement.
- 2** You are positive that your present investment allocation is taking full advantage of market performance.
- 3** You are confident that all has been done to reduce investment costs and taxation to maximize your retirement nest egg.
- 4** You have already taken advantage of every opportunity to minimize the largest tax you will ever pay – federal estate tax.

But... if you are concerned about taxes, inflation and retirement and want to know more about the science of winning investment strategies, this seminar is for you.

As your premier broker of high value services, Minnesota Medical Business Resources is sponsoring this AMA seminar, already attended by over 5,000 physicians. The AMA Investment Advisory Seminar provides unbiased, professional insight to help you build a better financial plan.

The cost to attend is just \$119.00 for MMA members, \$149.00 for non-members. Spouses are invited to attend free of charge.

Seating is limited for this full-day seminar so call today to reserve your place on Saturday, October 28th.

800-298-6627

Please stop by our information center at the MMA Annual Meeting in Rochester to explore all the financial services now available through MMBR.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

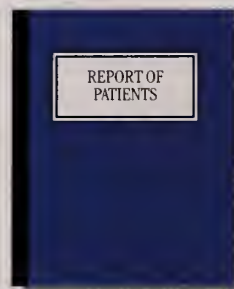
*A business corporation
of the MMA and HMS.*

WHEN TODD PETERSON PACKED HIS BAGS, HE LEFT SOMETHING BEHIND.



Todd Peterson became ventilator dependent following a traumatic motor vehicle accident. When Todd was deemed "unweanable" his family was told that he would live the rest of his life on a respirator. But so were Mrs. Moretti with chronic lung disease and Stephanie MacNeal battling a subarachnoid hemorrhage.

That's before HealthEast Bethesda Lutheran Hospital and Rehabilitation Center changed their lives. 30% of our patients considered unweanable were not only weaned, they packed up for home.



Call for our
white paper report and
updated statistics

Scope of services. General Medical Services • **Ventilator/Respiratory Care** • Wound Care
Neurobehavioral Services • Rehabilitation Inpatient Services • Swallowing Disorder Treatment
Capitol Heights Respiratory Residence • Geriatric Behavioral Care • Pain Management at
the **Minnesota Pain Center (MPC)**, located at HealthEast Bethesda Lutheran Hospital
and Rehabilitation Center, 559 Capitol Boulevard, St. Paul, MN 55103

For more information
Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS



152977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession
Pittsburgh, PA 15261-0001

*The primary care doc is in ...
Is the specialist out?*

OCTOBER 1995



THIS DOCTOR ISN'T JUST KEEPING UP. HE'S GETTING AHEAD.

This doctor has discovered what thousands of doctors already know: that one of the best ways to stay current is to subscribe to **AUDIO-DIGEST.**

Every year, Audio-Digest travels thousands of miles, to bring the best of the best—more than 350 of the top speakers and presentations in 13 specialties—directly to you. So you can listen when **YOU** want. It's the easiest and most cost-efficient way there is to benefit from and gain credit for your Continuing Medical Education.

Best of all, you set your own time and place to listen—whether it's at home, in the office, or out on the road. Which means you can keep up with more than just your medical education.

Call **1-800-423-2308** for your no-risk
FREE SAMPLE CASSETTE today. **AND FIND OUT JUST HOW
EASY IT CAN BE TO GET AHEAD.**



Audio-Digest Foundation®

All medical courses are planned and produced in accordance with the Accreditation Council for Continuing Medical Education (ACCME) Essentials. Program tapes are presented by Audio-Digest Foundation, a subsidiary of the California Medical Association. The California Medical Association is accredited by the ACCME to sponsor continuing medical education for physicians.

Each Audio-Digest program is approved for up to 2 hours of Category 1 credit, and may be applied toward the American Medical Association's Physician's Recognition Award and additional credit where designated by qualified boards and associations, including being acceptable for 96 hours annually of prescribed credit by the American Academy of Family Physicians.

0651

OCT 16 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Bruno Paciulli.

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 20 AUTHOR INSTRUCTIONS
- 61 NEWS CLIPS
- 65 CME IN MINNESOTA
- 67 CLASSIFIED ADS
- 72 INDEX TO ADVERTISERS

FACE TO FACE

- 6 SERIOUS BUSINESS** Thomas Allen
Marketplace forces have convinced Minnesota Specialty Physicians founder Burton Schwartz, a Minneapolis hematologist/oncologist, to stay active in the business of medicine.

COVER STORIES

- 8 SHOWCASING PRIMARY CARE** Howard Bell
Pushed into the limelight by managed care, will primary care docs find fame and fortune, or frustration?
- 15 SHIFTING BALANCE OF POWER** Maureen Reed, M.D.
HealthPartners is making its generalists "conductors" of the health care orchestra; its specialists are consultants and educators.

CLINICAL & HEALTH AFFAIRS

- 21 FORECASTING PHYSICIAN WORKFORCE REQUIREMENTS IN MINNESOTA**
Reinhard Priester, J.D., and Thomas E. Elliott, M.D.
- 29 RECRUITMENT AND RETENTION OF FAMILY PHYSICIANS**
Byron J. Crouse, M.D.

EDITORIAL

- 43 FREEDOM OF CHOICE IN HEALTH CARE TODAY:
MYTH OR REALITY?** Monica Wietgreffe
During a preceptorship, this medical student found that, despite limited health care choices, most patients are satisfied customers.

MEDICINE LAW & POLICY

- 47 DATA PRIVACY UNDER MINNESOTACARE** Mary Prentnieks, J.D., and Shirley Qual, J.D.
The 1995 Legislature created a complex scheme for protecting the privacy of data collected under MinnesotaCare.

SPECIAL REPORT

- 52 ONE FOR THE MONEY: THE FINANCIAL BENEFITS OF EDI** ... Sue Chapin-Strike
Electronic data interchange speeds the flow of data, reduces data entry errors, and ultimately saves money. First of three parts.

33 The Monitor

HIGHLIGHTS • MMA meets with congressional delegation on Medicare reform • How should Minnesota prepare for federal cuts and block grants? • MMA task force considers Medical Assistance reform

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$36. Single copies—\$3. Canadian—\$60. Foreign—\$60.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875. For national advertising, contact Lance Kincaid, State Medical Publishers Network, 800/788-2360.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1995-96 Officers

President
Michael J. Murray, M.D.

President-Elect
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Erick Reeber, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Andrew J. K. Smith, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.

N. Central District
James J. Dehen, M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.

East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
David C. Herman, M.D.
Noel R. Peterson, M.D.

Resident Member
Scott Stafford, M.D.

Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair

AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.

MMA Senior Staff

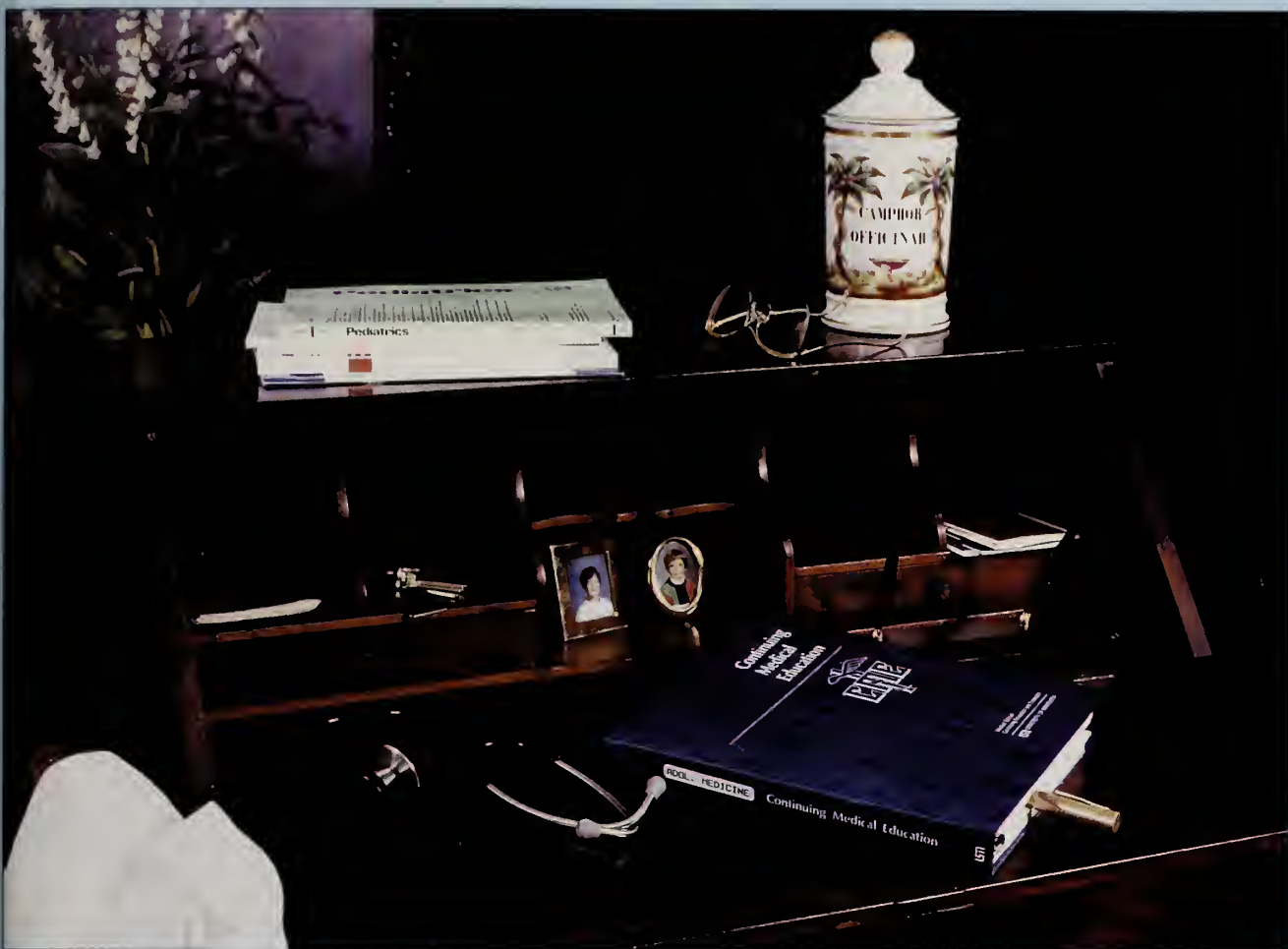
Chief Financial Officer
George C. Lohmer Jr.

Director of Legal Affairs
Patricia L. Franklin, J.D.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

Where knowledge and practice interact



CONTINUING MEDICAL EDUCATION

Continuing Education and Extension, University of Minnesota
Selected Courses, Fall, 1995

Internal Medicine Review
October 18-20 • Minneapolis

**International Symposium
on Innovative Therapies**
October 22-23 • Minneapolis

**Obstetrics and
Gynecology: Annual
Autumn Seminar**
October 26-27 • Minneapolis

**Carbon Dioxide Laser
Cutaneous Resurfacing**
October 28 • Minneapolis

**E.T. Bell Fall Pathology
Symp.**
November 3 • Minneapolis

**Cancer Center Symposium:
Team Approach to Head
and Neck Cancer**
November 3 • Minneapolis

**New Developments in the
Treatment of Mood and
Attention Disorders**
November 4 • Bloomington

**Annual Focus on the
Kidney: Useful Strategies
for Primary Care**
November 17 • St. Paul

1996

**International Symposium
on Current Topics in
Infection Diseases**
January 27-February 3
Zermatt, Switzerland

Brain to Pelvis: 1996
February 18-23
Beaver Creek, CO

**Geriatric Drug Therapy
Symposium**
February 21-22
Minneapolis

**Prevention and Treatment
of Atherosclerotic Disease**
February 23 • Minneapolis

Family Practice Review
May 6-10 • Minneapolis

**Topics and Advances in
Pediatrics**
June 11-14 • Minneapolis

**Trauma and Critical Care
Surgery**
June 12-15 • Minneapolis

Continuing Medical Education, Medical School, Continuing Education & Extension
Radisson Hotel Metrodome, Suite 107, 615 Washington Avenue S.E., Minneapolis, MN 55414
(612) 626-7600 • The University of Minnesota is an equal opportunity educator and employer

See our new listing on World Wide Web at <http://www.cme.cee.umn.edu/>
Listing includes calendar, brochures, and connections to Mpls.-St. Paul events listings.

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

**To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)**

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

The Tension Is Palpable

Charles R. Meyer, M.D.

American College of Physicians to host specialty summit.

—ACP News

Much of today's rhetoric in medicine has a military flavor to it. The AMA battling Congress. HMOs dueling with providers. Hospitals digging trenches in a war with their competitors. And, as the above ACP headline suggests, doctors are facing a potential internecine war between specialists and generalists. The goal of the ACP summit was to bring "together all the subspecialists with general internists to work out agreement about how referral patterns should work." (They didn't mention how long it took to decide the shape of the table.) Is the profession really at war with itself? Do we need summits and mediators to work out our differences? This month's *Minnesota Medicine* examines this putative professional pugilism.

Our cover story sets the scene with an overview of generalists' newfound popularity in Minnesota and elsewhere. Our profile features Minneapolis hematologist/oncologist Burton Schwartz, a local physician leader who has spearheaded the formation of a proactive specialty organization, Minnesota Specialty Physicians, and is retiring his badge as Hennepin Medical Society president to become the society's board chair.

We've turned to Maureen Reed, M.D., medical director of the Contracted Care Division of HealthPartners, for a description of how one managed care organization approaches the sticky problem of specialists and generalists. The picture that emerges suggests at least rumbling in the ramparts, if not overt gun play.

What has triggered all this com-



"Is the profession really at war with itself? Do we need summits and mediators to work out our differences?"

motion? The simplistic answer is money. Money has inspired the migration of medical school graduates to higher-paid specialties. Money has led government and third-party payers to try to limit spending on expensive specialty care and procedures. Money has caused specialists and generalists to retrench as they see their livelihood threatened. Scarcity is one of the classic causes of war. All players in the current saga are maneuvering as the health care system reacts seismically to limited resources.

So far, maneuvers look like this: Seeing double-digit health care dollar inflation, the government is trying to shift the balance of care to generalists by altering specialty training choices, redistributing physician compensation in favor of generalists, and reducing its overall spending on provider services. Fearing expensive specialty care as they assume more risk, third-party payers are devising new rules, like gatekeeping and cap-

itation, to limit access to specialists. Sensing the generalist tide, medical educational institutions are finding primary care role models for their students and residents and teaching new skills like epidemiology and decision analysis. Responding to these incentives, medical students in the past two years have increasingly veered toward primary care residencies. Meanwhile, generalists are struggling with gatekeeping, prevention, and cost-effectiveness, and specialists are trying to keep doing what they were trained to do without taking a giant hit in the pocketbook.

It's change and it's uncomfortable. Nobody likes it. Government and third-party payers don't like paying the bills. Generalists don't like processing referrals and worrying about capitated dollars. Specialists don't like scrambling for patient access and defending the value of their work. And patients don't like the hoops they have to navigate to see the doctor they want to see.

Whether it's the breakup of Yugoslavia or the demise of slavery, change can cause wars. In some parts of the country, the specialist/generalist rift has turned nasty and bellicose. But change can also cause growth. I prefer to see Minnesota's current turmoil between specialists and generalists as creative tension between two groups besieged by change. Like many combatants, each group has its own interests, which seem incompatible with the other group's. Like threatened armies, each has started circling the wagons. But unlike true war adversaries, specialists and generalists have a common heritage of ideals, training, and goals, which speak for unity rather than enmity. Unless specialists and generalists realize that we're in the same trench, we'll all lose the war.

MM

SERIOUS BUSINESS

MARKETPLACE FORCES
HAVE CONVINCED
ONCOLOGIST BURTON
SCHWARTZ TO STAY
ACTIVE IN THE BUSINESS
OF MEDICINE—AND TO
FORM THE CLINIC
WITHOUT WALLS
MINNESOTA
SPECIALTY PHYSICIANS

Thomas Allen

In an atmosphere where the management of medicine is nearly as important as the practice of medicine, Minneapolis oncologist Burton Schwartz, M.D., believes physicians should take their business seriously. "The hope is that the physician-patient relationship is more likely to be preserved if physicians are in control of the major portion of the delivery system," Schwartz says. "The concern is that you can't do both. After a

"THE HOPE IS THAT THE PHYSICIAN-PATIENT RELATIONSHIP IS
MORE LIKELY TO BE PRESERVED IF PHYSICIANS ARE IN CONTROL
OF THE MAJOR PORTION OF THE DELIVERY SYSTEM."

while, physicians see you as a manager who is not a physician, as opposed to a manager who is a physician. That's troublesome."

As president of the 24-physician Minnesota Oncology Hematology, P.A. (formerly Oncologic Consultants, P.A.) and executive officer of Minnesota Specialty Physicians, Inc., a 220-physician clinic without walls, Schwartz is performing that balancing act, splitting his time between hematology/oncology and management. It's a dual role that keeps him on call from 7 in the morning until 9 or 10 o'clock at night, leaving little time for his favored spy novels and science fiction books, or the occasional game of tennis.

Schwartz tries to separate the clinical and management sides of his practice by designating some days as clinical and others as management. But, as with all of medicine, it's rarely that clear-cut. "I have to make rounds even on those management days. And on the clinical days, I typically have a number of meetings interspersed throughout the day," says Schwartz, who is board certified in internal medicine, oncology, and hematology, and received his certificate in physician management from the College of St. Thomas in 1992. He also devotes time to giving lectures at Hennepin County Medical Center (HCMC) and Abbott Northwestern Hospital in Minneapolis, as well as performing his duties as a Hennepin Medical Society officer. On October 1, Schwartz relinquishes his title as

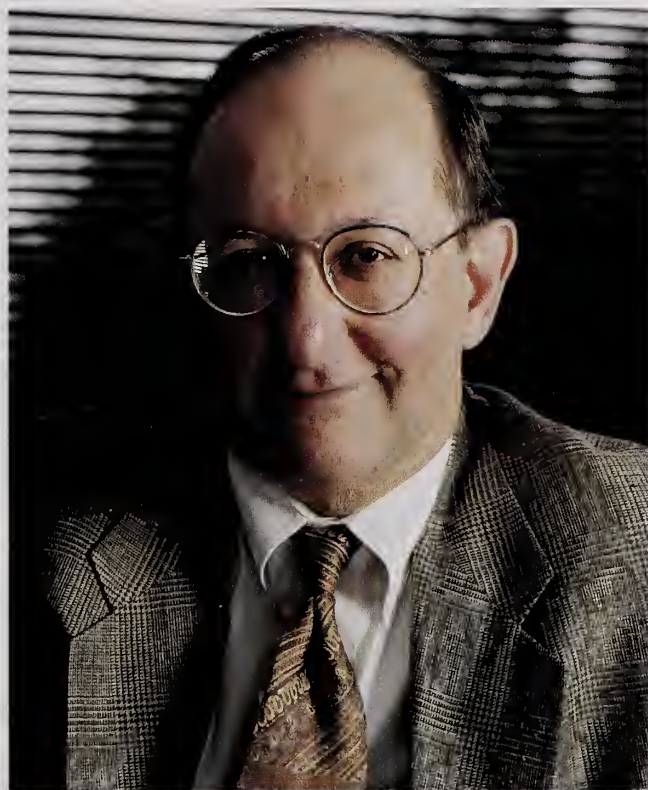
president to become chair of HMS's board of trustees.

Schwartz, who in 1974 moved from Chicago to Minneapolis with his wife, Sharon, and their two young children, is used to dividing his time. In his early days at the Minneapolis Medical and Diagnostic Center, Schwartz spent half his time practicing hematology/oncology and the other half in internal medicine. Over time, his hematology/oncology practice grew until it ate up 90 percent of his day. In addition, he taught at HCMC, where he was named teacher of the year in 1982, and Mount Sinai Hospital, where he was chief of staff in 1987, and where he was named teacher of the year in 1982 and again in 1987.

The Business of Medicine

When he joined a small group practice across from Mount Sinai 20 years ago, Schwartz says, medicine was "almost a cottage industry," with very little regulation. But in the two decades since he moved to Minneapolis, medicine has seen the rise of managed care, large specialty and multispecialty clinics, physician-hospital organizations, and now, integrated service networks.

In the 1970s, Schwartz didn't pay much attention to managed care because it represented such a small



PHOTOGRAPH BY BRUCE BAIRD

portion of his practice. However, by the mid-'80s, when Physicians Health Plan (PHP) experienced difficulties with its physician network, Schwartz became more concerned—and involved. He served on the PHP Oversight Committee, which had a role in overhauling PHP, and later held seats on the PHP board and then on the Medica board.

He also served on the Health One board during its merger with LifeSpan and survived to serve on the HealthSpan board. With seats on the Health-

Span and Medica boards, Schwartz saw the evolution of Allina Health System from both sides and now serves on the Allina board.

ONE OF THE MOST SIGNIFICANT CHANGES FOSTERED BY MANAGED CARE IS ITS EMPHASIS ON PRIMARY CARE PHYSICIANS AS "GATEKEEPERS" TO HOLD DOWN COSTS.

Like many physicians, Schwartz is concerned about the rapid consolidation in the market, which, he says, makes it difficult for physicians to remain independent. "But I don't think we'll go back in the other direction. So we have to learn to adapt and live with it if physicians are going to be influential," he says.

SCHWARTZ continued on page 56



Pushed into the limelight by managed care, will primary care docs find fame and fortune, or frustration?

Showcasing Primary Care

Each week, Greg Poland, M.D., fills a 30-gallon can with junk mail, a pound of it brochures and letters urging him to join other clinics. He gets five calls a week from recruiters

asking if he is interested in primary care opportunities. Poland is not a resident about to take his first job. For seven years, he's been a Mayo Clinic internist, a primary care physician—managed care's hot commodity.

All non-fee-for-service structures in which payers call the shots have

By Howard Bell

helped showcase primary care: from tightly structured HMOs to open networks and third parties who manage self-insured plans that demand provider discounts. Sixty-four percent of Minnesota's population is enrolled in some type of managed care health plan that restricts access to specialists and limits reimbursements either through discounts or capitation. The number is expected to reach 70 percent to 90 percent by the year 2000.

Top Billing

As purchasers and payers obtain greater control over medicine, they recruit general internists, family practitioners, pediatricians, and ob/gyns to control costs by acting as so-called gatekeepers. Many prefer the less loaded term "coordinators of care." Regardless, patients must see a primary caregiver before they can see a specialist.

"We've seen a definite increase in demand for primary care docs over the last three to four years," says Karen Sturm, director of Physician Services for the Minnetonka-based Allina Health System. "Prior to that, we had a great demand for specialists. Now it's the family practitioners and general internists who are selective and want more money."

They're getting it, too. According to Hays Physicians' Total Compensation Survey, between 1992 and

1994, family practice salaries nationwide rose 14 percent to a median \$123,700. Pediatric salaries climbed 18 percent to \$132,900, and general internists enjoyed a 27 percent jump to \$137,400. Specialists' salaries, meanwhile, were unchanged and in some cases declined.

"The economics have changed," says Terry Rosborough, M.D., director of Abbott Northwestern's internal medicine residency program. "It's getting harder in the Twin Cities for subspecialists to find positions."

The Duluth Clinic used to consider itself a multi-specialty group of consultants with little primary care, according to James Brueggemann, M.D., medical director. Now it's in the process of sculpting a medical staff pyramid with at least 50 percent primary care at its foundation. "We're almost there," he says. "We've shifted to building integrated networks emphasizing primary care and decentralization."

Market forces and government policy have redesigned the stage on which medicine is practiced. Payers and government sit in the director's chair, and they're recasting the players. The shift occurred so fast, the supply of leading men and women hasn't caught up with demand. At least 75 percent of the physicians Allina recruited last year are in primary care. "We have five primary care jobs for every candidate," Sturm says. "I reached one physician's answering machine that told me, 'If you're a recruiter trying to recruit me, please hang up now.'"

Getting the Message

Forty percent of Minnesota physicians practice primary care, excluding ob/gyn. That number is likely to increase and eventually balance out supply and demand as medical students get the message and choose generalist careers. (See "Forecasting Physician Workforce Requirements in Minnesota," page 21.) Nationwide, students interested in pursuing generalist careers increased for the second year in a row, according to the Association of American Medical Colleges. Students entering internal medicine residencies jumped from 14 percent to 21 percent in 1994. Family practice climbed to 32 percent, a 6 percent increase. Subspecialties like radiology, anesthesiology, and ophthalmology all experienced declines.

In the past, only 25 percent of Mayo's internal medicine residents did not subspecialize; 46 percent chose not to in 1994, according to Roger Nelson, M.D., Mayo's



ILLUSTRATIONS BY BRUNO PACIULLI

vice chair for education. "We've certainly seen a trend toward not subspecializing," he says.

"Our country has chosen a medical model with a strong role for primary care," says Abbott's Terry Rosborough. "It's influencing decisions medical students and residents make because they want a job." The percent of Abbott residents not subspecializing remains unchanged, but only, says Rosborough, because Abbott has always had about 90 percent generalists.

Responding to the shrinking demand for specialty physicians and to budget shortfalls, the University of Minnesota Academic Health Center last month announced plans to reduce the number of physicians receiving specialty training by 25 percent. The proposed reduction, to begin July 1, 1996, would elim-

inate about 350 of more than 1,300 specialty training positions to save money and adjust the specialist supply to the state's needs, health center Provost William Brody, M.D., Ph.D., told the university's board of regents.

Already, the university is one of just two schools in the nation with more than half their medical students choosing primary care residencies. The number jumped from 54 percent in 1992 to 65 percent last year. "The increase reflects the marketplace," says Robert McCollister, M.D., associate dean of curriculum for the medical school. "Primary care is where the jobs are."

Script Please

A new show requires new scripts. All Minnesota training programs are overhauling their curricula to better train students for cost-conscious managed care environments that emphasize preventive primary care. Rotations now



Ob/Gyns Caught in the Middle

Medicine, like life, has many shades of gray. What is primary care? Who is qualified to practice primary care? Can specialists be gatekeepers, too? As direct access to patients slips through their fingers, specialists are crying foul. Perhaps rightfully so, especially for ob/gyns. In some parts of the country, HMOs and other payers have taken away ob/gyns' slice of the primary care pie. No more direct access. Few such barriers now exist in Minnesota, but

some ob/gyns worry that the problem could arise here unless legislative initiatives are passed to prevent it.

Part of the problem is defining primary care, according to Janette Strathy, M.D., who practices ob/gyn at Park Nicollet and is president of the Minnesota Ob/Gyn Society. "Does primary care mean doing everything, or does it mean doing everything the patient needs?" Strathy asks rhetorically. "Preventing women from having direct access to ob/gyn when all they need is ob/gyn contradicts the philosophy of efficiency that's part of managed care."

Strathy says she is the only doctor half her

patients see, because the only thing they need is ob/gyn care. Statistics show that's true elsewhere, too. A 1993 Gallup poll found women are more likely to have had a physical exam within the last two years by an ob/gyn than any other type of doctor (72 percent vs. 57 percent). Fifty-four percent of respondents consider an ob/gyn their only primary care doctor.

Strathy says ob/gyn is part primary care, part specialty, but insurance companies try to pigeonhole it as one or the other. "You can't pigeonhole women's health," she argues.

Ob/gyns appear to be good-faith practitioners of managed care; among all primary care doctors, ob/gyns have the lowest rate of referral to specialists (4 percent). As for treating non-ob/gyn problems, Strathy says, "Most ob/gyns don't want to be primary care doctors in the broader sense. The patients I see know not to come to me with sprained ankles and sore throats. All we want to do is maintain the status quo, let women with ob/gyn concerns choose us as their primary care doctors."

From a purely practical standpoint, Strathy says if ob/gyns were denied primary care status, there would not be enough primary care docs to handle the load. "To exclude us would be crazy," she says.

place more emphasis on community health, epidemiology, interviewing techniques, decision analysis, and interdisciplinary collaboration.

"Everyone is changing their curricula," says Rosborough, "but no one is sure what the right way to change it is. There are so many types of managed care. Educators have to decide what the generic or universal issues are and adapt curriculum accordingly."

As part of their training, internal medicine residents at the university see patients at managed care clinics operated by HealthPartners. Residents at Mayo and the university rotate through "continuity clinics," in which residents see a panel of patients over a period of time. Mayo residents attend lectures on managed care case scenarios and presentations on ethical and legal issues.

Internal medicine residents at Hennepin County Medical Center now have a behavioral medicine rotation

"because 20 percent of what you see in an office practice is behavioral," says Morris Davidman, director of HCMC's internal medicine residency program.

HCMC offers a community medicine managed care rotation through HealthPartners. It also has added a 10-week ambulatory block emphasizing skill building for sigmoidoscopies, exercise stress testing, HIV care, and patient referral to specialists. Over the last five years, Hennepin has increased the number of internists on its faculty from zero to 23. They now make up more than one-third of its entire faculty. "What it's all about is modifying curriculum so that career choices are apparent," Davidman says. "What society wants is what we shall give them. Our money is where our mouth is."

Curriculum changes may already be paying off, says Donald Asp, M.D., a family physician with Bethesda Family Physicians, a university teaching clinic in St. Paul. "We used to have trouble recruiting," he says. "It's not so difficult now because the university is giving primary care a better shake. Students get better mentoring and develop a greater respect and interest in primary care."

Calling Dr. Welby

Managed care is dramatically altering the perceived value of primary care, bringing respect, acknowledgment, and higher salaries. "Primary care doctors now have the opportunity to influence how medical care is delivered," says Poland. "But now that we're admirals of the ship, they've decided to dismantle the navy. Medicine as we know it is being radically changed. More and more, the doctor-patient relationship is tainted by the bottom line."

A lot of what managed care has done for primary care is good, says Doug Hiza, M.D., medical director for First Plan of Minnesota, an HMO that owns three clinics in Duluth and Two Harbors. "Managed care empowers primary care doctors to practice good medicine by making good, appropriate referral choices," he says. "If anything, quality is better under capitation because quality means referring at appropriate times and making appropriate use of resources. Providing everything does not equal quality."

Ray Christensen, M.D., of Gateway Clinic in Moose Lake agrees. "Research has shown the benefits of primary care over specialty care in terms of cost-efficiency and outcomes," he says. "People are asking for it. They want Marcus Welby."

Managed care puts the focus on primary care, where it should be, says Park Nicollet ob/gyn Janette Strathy, M.D. "It's important for patients to have a doctor who sees the big picture." Managed care also fosters effi-

Strathy, herself, is somewhat buffered from direct access barriers because her patients are insured through HealthPartners, which recognizes her primary care role. Others aren't so protected. Like Doug Soderberg, M.D., with Paul Larson Clinic in Edina. He doesn't blame other primary care doctors. "They're just following the rules," he says. "Our biggest problem is with Blue Cross/Blue Shield's Blue Plus plan. They won't allow patients to see me without a referral. I've lost a lot of patients, and I hear from a lot of patients who are upset. Sometimes by the time patients get to me, they've gone through a lot of unnecessary workup. That's not efficient."

The Minnesota Ob/Gyn Society has submitted to the MMA House of Delegates a resolution acknowledging women's need for direct access to ob/gyn care. (The House is considering the resolution as *Minnesota Medicine* goes to press.) "We're asking that direct access be preserved for those women who feel we meet their needs best," says Strathy.

In California, a new law requires managed care organizations to let ob/gyns be gatekeepers as long as they agree to provide initial care, follow their patients, and limit referrals. Similar laws have passed in a handful of other states.

—HB

ciency, Strathy believes. "Now we have to think about what's appropriate instead of ordering up the usual 20-blood panel."

An emphasis on primary care favors the wellness model of health care instead of the illness model, another

benefit, many physicians believe. "People are listening to the message of prevention," says Poland. "They're listening because there's an economic incentive to listen, but nevertheless, it's a positive." For example, hospitals and managed care organizations, he says, are starting to take

What's a Specialist to Do?

Virtually everyone agrees that managed care has significantly decreased demand for specialists, despite the explosion of new medical technologies. It's happening in Minnesota, but it's even more pronounced elsewhere. Says Allina recruiter Karen Sturm, "I can't tell you how many specialists call us wanting to relocate in Minnesota because they've been forced out of their practice or there's a glut."

It's so bad elsewhere, specialists are retraining to practice primary care. Minnesota has no formal programs to retrain specialists. "Most programs don't know how to do that anyway," says Terry Rosborough, M.D., director of Abbott Northwestern's internal medicine residency program. "It's inefficient to throw [specialists] back into residency. You need to create a totally separate program. For us, there's been no pressure to do that yet."

The number of Minnesota medical students choosing specialties has declined, and the number of internists subspecializing is down because primary care is where the jobs are. Meanwhile, specialists struggle with a system that has de-emphasized the relative value of specialty medicine. Many specialty groups find it difficult to land contracts and to compete with large groups to recruit doctors. Yet many want to remain independent rather than serve as revenue balancers for primary care departments. As Rosborough puts it, "They don't want to be 'Robin Hooded.'"

Of course, a larger issue faces specialists and primary doctors alike: How do physicians retain control of medicine in the face of managed care pressures that divide and conquer? "Managed care creates divisiveness between the two groups," says Tim Signorelli, CEO of Minnesota Specialty Physicians, a 220-physician clinic without walls. "It plays into the hands of those who want to control the market."

Specialists have the most to lose in managed care. So it's not surprising that they're the ones who've

come up with innovative ways to retain market control. One strategy is to assume some capitated risk, like primary care physicians do. That's what Orthopaedic Associates in Duluth did when they signed a capitated contract with First Plan of Minnesota.

"We're First Plan's sole orthopedic provider," says Mark Carlson, M.D., a physician with the Duluth specialty group and president of the Minnesota Orthopaedic Society. "To say we're accepting some of the risk is an understatement. But it's part of our strategy to provide top-quality orthopedic care and maintain excellent rapport with every primary care physician and every managed care plan that will work with us."

Carlson says Orthopaedic Associate's relationship with primary care groups is cooperative, not antagonistic. "What's antagonistic to us is an insurance company CEO who makes \$9 million while obstructing access to quality care," he says.

The Minnesota Orthopaedic Society plans to address that concern by supporting state legislative initiatives to do two things: First, any insurance plan, regardless of how it's formulated, must offer its patients "point-of-service" options. That means if patients want to see a specialist, they have that option, even if it means going outside the system and paying extra for it. Minnesota included a point-of-service option in the MinnesotaCare bill, but it was pulled at the last minute. "It's mandated in at least three or four states now," says Carlson. "We should make it a law here, too."

Second, doctors should not be compensated for not referring. "The fewer-patients-equals-more-money formula is bad for patient care," Carlson says. "Yet this happens all the time in closed-panel HMOs. Forget about the money. Put quality of care first and everything else falls into place."

Shifting attention away from the bottom line and back to the doctor-patient relationship is the idea behind several physician-led specialty care systems

immunization seriously because it's cheaper than sending patients to the hospital.

Is Bigger Better?

Considered a boon by some physicians and a boondoggle

by others, managed care is pressuring smaller primary care practices to affiliate with big systems. Affiliation may not be good for all small primary medicine practices, but it has benefited Wayzata Internal Medicine, according to Bill Tiede, M.D. He and his six partners recently

in Minnesota. They're basically clinics without walls, joint ventures between primary care physicians and specialists, according to Minnesota Specialty Physicians' Signorelli.

MSP's 220 members, for example, have created a joint venture called Minnesota Quality Care Network with 65 primary care doctors at Fridley-based Columbia Park and 24 at Quello Clinic in Bloomington. "We've created a partnership with them to share services and practice guidelines and reduce overhead," Signorelli explains. "We're trying to overcome the divisiveness managed care creates between the two groups. We're trying to retain continuity of patient care and prevent patients from losing their doctor or being bounced around when they change plans, all while providing one-stop shopping for purchasers."

Minnesota Quality Care plans to standardize registration forms so patients don't have to complete duplicate forms for every referral. The group will use computers and E-mail to send medical records and other communications among physicians. Capital Management Specialists and East Metropolitan Health Organization, both in St. Paul, are variations on the same theme.

The Minnesota Clinic in St. Cloud incorporated last July with a membership of 60 physicians, 70 percent specialists. "Discounted fee-for-service is not good for specialists," says gynecologist Nelson Sirlin, M.D., the Minnesota Clinic's president and CEO. "Health plans have become very intrusive on specialty practices. We want to retain identity. We don't want to be plan-owned or hospital-owned."

Minnesota Clinic is now negotiating with plans and large employers to be their preferred provider. The clinic's board of directors is half specialists and half primary care physicians. They sign contracts, including capitated ones, on behalf of all their doctors.

"Sellouts [to bigger systems] are a short-term strategy," Sirlin says. "They pose long-term prob-

**"Managed care creates
divisiveness between
primary care physicians
and specialists."**

—TIM SIGNORELLI

lems with productivity, and with incentives to work hard and advocate for the patient."

Criterion HealthCare Network in Minneapolis is a larger, slightly less integrated physician-led care system with 200 specialists and 250 primary care doctors. Members buy in and own the delivery system. "The idea," says Criterion Executive Director Douglas Shaw, "is to break down barriers between primary care and specialists to create a structure and incentive for both to work in comfortable, collaborative partnership." Physicians work together to develop clinical guidelines that get patients to the most appropriate doctor at the lowest cost. All doctors work under a common fee schedule, analyze clinical outcomes, review utilization, and market [their services] together.

Criterion offers what the purchaser desires: gatekeeper programs, closed or open access, and what Shaw calls "modified gatekeeper."

"We feel it's more appropriate and efficient if some patients move quickly to a specialist," says Shaw, citing diabetes, serious fractures, and eye problems as illnesses that demand specialty care. "In a sense," says Shaw, "we've become a Park Nicollet without walls."

—HB



"It's an onerous job being a gatekeeper. Specialists are afraid the primary care doctor won't refer. The primary care doctor is afraid he'll be accused of not referring soon enough."

—DOUG HIZA, M.D.

became salaried when they joined HealthSystem Minnesota, which also owns Methodist Hospital and the Park Nicollet Clinic. "We felt the pressures common to all smaller, independent groups," Tiede says. "Increasing overhead, decreasing reimbursement from payers. It was clear to us we'd have an increasingly difficult time making it on our own."

Now Wayzata Internal Medicine has financial stability. Overhead is under control. Profit margins are higher. Access to deeper corporate pockets makes it easier for Wayzata to recruit new physicians. "We've got a steady stream of patients and more office space," Tiede says. "Business aspects of medicine are no longer a burden to us, so we can focus on patient care."

Choosing independence over affiliation, Blue Earth family practitioner Terry Cahill, M.D., left a small group practice three years ago to go solo. He, too, is holding his own in the managed care arena, though he's proof that a solo or small group practice must work exceptionally hard under managed care. He sees 35 to 45 patients a day, not including hospital visits.

"My income is up, and I'm enjoying it more," Cahill says of his practice. "I'm busy because I take every network available. No capitation, just discounted fees. Every week my patient load increases. I have more options open to me. I can support the local hospital as much as I want. They appreciate what I do."

His own success aside, Cahill is not entirely happy with the primary care doc's lot. For starters, promised improvements in RBRVS (resource-based relative value scale) reimbursements have been a disappointment. Medicare reimbursement for primary care increased 19 percent from 1991 to 1993, according to a Physician Payment Review Commission report to Congress. But some physicians have observed an overall failure of primary

care revenues to keep up with practice costs.

Says Cahill, "RBRVS and other prospective payment mechanisms have not significantly improved. The difference between primary care and specialties is still astounding. We are still undervalued and dismally under-compensated. We keep talking about what to do with inefficiencies in the system while these reimbursement gaps stare us in the face."

Reimbursement differences are particularly unfair, says Cahill, when you figure in time-consuming pre-approval obstacles. "Recently, it took me and my staff three hours just to get a woman in mental health crisis into an appropriate care setting," says Cahill. "She couldn't go to hospital X. She couldn't see provider Y. Then the psychiatrist keeps her in the hospital for a week and gets reimbursed for consults and visits. I got 40 bucks. Some physicians would be financially penalized for getting her that care. Meanwhile, my other patients suffer because I'm on the phone with pre-approval people. Where's the savings in that?"

Paperwork and constantly changing guidelines can also raise Cahill's ire. "We just signed up with Medica, and they dropped off three binders of rules. It's not realistic for our staff to have to wade through all that." Working with HMOs requires Cahill to follow their guidelines, protocols, and prescribe only the drugs they recognize. It's not unusual for HMOs to impose non-negotiable and undesirable contractual terms. "Who's the doctor?" he wonders.

Managed care's emphasis on primary care makes recruiting particularly tough for rural clinics, whose pockets aren't as deep and whose location is not always as desirable as urban clinics'. "Not only have salaries gone up," says Cahill, "but you actually have to offer more to compete with the Cities. I have to guarantee a salary I'm not even making."

The experience is similar in Moose Lake, says Gateway Clinic's Christensen. "We need to raise salaries 5 to 10 percent a year to remain competitive. Our established doctors tend to finance new salaries at the expense of their own."

Of course, money is only part of the recruitment formula. "Most primary care physicians today are not looking for big bucks," Christensen says. "You can't buy a rural doctor with money. You have to offer them an attractive environment." (See related article, page 29).

Part of creating an attractive environment is what Christensen calls sub-regionalization. "You need a minimum of six to 10 docs working together so you can share

PRIMARY CARE continued on page 58

ILLUSTRATIONS BY BRUNO PACIULLI



Shifting Balance of Power

HealthPartners, like many Minnesota health plans, is making its generalist physicians "conductors" of the health care orchestra, while molding specialists into consultants and educators.

Change. The word simultaneously excites and frightens people. In Minnesota's health care industry, change has simply become the norm. The latest transformation facing physicians is the shifting balance of power between generalists and specialists—a shift in influence, autonomy, and money.

The changing roles of generalists and specialists is a subject of intense interest to HealthPartners, which is both a managed care health plan (an HMO) and a large multi-specialty health care delivery system. HealthPartners was created by the 1992 merger of Group Health and MedCenters. Previously, Group Health was both a staff-model HMO

By Maureen Reed, M.D.



with an owned delivery system, the Group Health clinics, and a group-model HMO with a contracted delivery system of 14 affiliate medical groups. MedCenters was a group-model HMO with a contracted delivery system of 18 affiliate medical groups, the largest being Park Nicollet Medical Center.

Currently, the delivery systems that serve HealthPartners members are the 26 owned multispecialty HealthPartners

clinics (serving 320,000 members with 270 generalists and 220 specialists), the 38 contracted primary care and multispecialty medical groups (serving 350,000 members with 1,060 generalists and 400 specialists), and the St. Paul-Ramsey Medical Center. HealthPartners contracts with an additional 2,500 specialists who practice in single-specialty groups.

It is fair to say that the history and philosophy of the care delivery system heavily influences the health plan, and likewise, that the history and philosophy of the health plan influences the care delivery system.

As we fulfill our mission to improve the health of our members and our community, we feel the strong influence of external factors that are shaping the new roles of generalists and specialists.

Patients increasingly insist that personal care, delivered when and where they desire it, is crucial. They ask to be treated as whole persons, rather than diseased organs. They obtain most of their medical information from nonmedical sources and fervently believe in miracle cures that derive from high technology. Although they rarely articulate it, patients are beginning to understand that inconsistency, duplication, and excessive care represent poor care. Essentially, they require someone to shepherd them through a complicated system and provide reliable answers to complex health problems.

Like patients, payers also have needs that are shaping the future roles of generalists and specialists. To keep afloat, business and government require a lower cost of

health care and proof of responsiveness to their needs. They unambiguously state concerns about inconsistency of care and lack of proven efficacy. Both payers and patients expect a higher quality of care and service than has been available in the past.

These expectations are legitimate and compelling. An extremely high level of integration of systems and of people is necessary to deliver care that is higher quality, lower cost, and that satisfies patients' specifications. To achieve this integration and satisfy payers' and patients' expectations, generalists and specialists at HealthPartners are changing the way they relate to one another.

Historical Roles and Compensation

In the HealthPartners-owned delivery system (formerly the Group Health-owned clinics), clinical roles of physicians were shaped by the 30-year history of a multispecialty group practice. Generalists were expected to provide for the needs of the vast majority of patients, to refer patients when necessary, and to remain in touch with specialists and patients. Referral guidelines, if existent, were unwritten, but specialists were discouraged from referring patients for additional care without the knowledge and approval of the generalist. Because the ratio of specialists to generalists was lower than what was generally true in the community at large, specialists were more likely to act as consultants than to assume total care of the referred patient. Moreover, direct self-referral of patients to specialists did not often occur. Treatment that could not be provided by employed specialists was performed by contracted specialists upon referral.

Historically, both generalists and specialists were paid salaries that would assure their retention, but generalists were easier to recruit and retain than specialists. Neither group was at risk for the financial performance of HealthPartners, but both shared in the potential for reward—salary increases—during years of surplus.

The HealthPartners' contracted delivery system (the former Group Health and MedCenters affiliate clinics) historically consisted of a few multispecialty groups and many single-specialty primary care groups. In these single-specialty primary care groups, generalists were expected to provide for the needs of the vast majority of patients and to refer patients when necessary. Referral guidelines generally were not explicit, and it was unsettlingly frequent that, once referred, a patient would subsequently be referred to other specialists without the primary care physician's knowledge. Whether the generalist remained involved in the care of the patient following referral depended upon the relationships and, some-

times, competing desires of the generalist and specialist.

A contracted generalist's payment for care of HealthPartners' members followed the compensation method determined by his or her medical group. In most cases, this was a production formula. The primary care medical group itself, however, was capitated (adjusted for patient age and sex) for professional services, hospital services, and referral services rendered to HealthPartners' members. Often HealthPartners shared capitation risk with the medical group.

In contrast, specialty groups were usually not paid by capitation, but were paid on a fee schedule from the referral fund of the primary care medical group. The individual specialist was then compensated according to the formula of the specialty group's choosing.

The New Philosophy

How are these old models changing in response to the patient and payer demands cited earlier? HealthPartners' philosophy

"Specialists who effectively meet the cost, quality, and service needs of the generalist will be successful."

is that a patient receives the best care when a well-functioning primary care team takes responsibility for planning and orchestrating that care. To serve the patient well, this model must include several features: Primary care physicians must be highly com-

petent as generalists, and they must be highly competent as integrators of care. Specialists and facilities must be technically competent, and they must understand and support the generalist. Finally, financial incentives must be properly aligned among these various entities.

At HealthPartners, we often use the analogy of an orchestra to describe how a care team should work. The conductor bears primary responsibility for producing a unified result. While not pretending to know how to play each instrument, the conductor understands the potential contribution of each orchestra member. The conductor understands when a soloist should enter and exit, when the violins must be subdued, and so on. In the end, the conductor assures that the entire orchestra provides the audience with a harmonious performance.

In the recent past, medical care has not necessarily been delivered under such well-ordered circumstances. Care may not have been coordinated at all; more than

one conductor may have been present, soloists may have tripped over each other, and orchestra members may have simultaneously played from entirely different scores. At a time when care was simple and options few, this may have been acceptable. In today's health care world, the results of poor orchestration range from frustration to medical complications and death.

The generalist as conductor

In the future, which is fast becoming the present, the HealthPartners' generalist will become the major decision-maker and conductor of care for populations of patients. Whether practicing in the owned or the contracted delivery system, the generalist, as care team leader, will be responsible for identifying when and how other health care professionals serve their patients' needs. Because many generalists have had little formal training in team leading and collaboration, this educational need is just beginning to be addressed. Generalists must learn how to effectively lead teams that are characterized by strong internal support and respect, that maximize the contribution of all members by appropriate training and delegation, and that know their capabilities and limitations.

Quality care by generalists will include setting precise expectations in advance of the consultation. The generalist will be required to clearly state what role the specialist is to play, what specific question is to be answered, and how the answer is to be communicated to the patient. No longer will it be acceptable for a patient to show up at the specialist's office without an explicit purpose. The generalist also will be required to take more responsibility for delivering the news of a poor prognosis. Gone are the days when a generalist will refer an unsuspecting patient to the specialist to receive the "bad news." Also past are the days when a patient with a serious or terminal condition will be shipped to the specialist never to return. The generalist of the future will remain involved in the care of complex patients and retain care responsibilities for terminal patients in order to optimally address the psychological and social needs of the patient and family.

While some generalists will provide both inpatient and outpatient care, many will increasingly emphasize ambulatory care. Moreover, the concept of providing care to a *population* of patients (rather than individual patients) will more strongly take root among these generalists.

Further, the generalist will be required to educate the patient about the orchestrating role and will be required to truly collaborate with the patient in decision-making

and care planning. Many patients only partially understand the chaos that results from poorly coordinated care. Moreover, many are unaware of the capabilities of generalists and believe that they must see a specialist in order to receive good care. Finally, the generalist will be expected to develop treatment guidelines and to practice and preach evidence-based medicine.

The specialist as teacher

Whether serving the owned or the contracted delivery system, the HealthPartners' specialist of the future will serve primarily as consultant and educator to the generalist. In this role, the specialist will be a member of the care team, entering at the request of, and within the parameters set with, the generalist. No longer will the specialist call in other specialists or assume charge of the case without the generalist's direction. While some specialists will be tied to a particular high-technology facility, others will move into the community to provide the generalist better access to services and expertise on an ambulatory basis.

Specialty care that remains tied to high-tech facilities increasingly will be delivered in diabetes centers, trauma care centers and the like, rather than in specialty-designated endocrinology and cardiac clinics, for example. These centers' main objectives will be high-tech intervention, education, and episodic, rather than continuous, care. The specialist will be the conductor of ongoing care in only a small number of cases. During that time, the specialist will be required to lead the team of other health care workers and specialists. Specialists, therefore, will also need training in teamwork.

Like generalists, specialists will be required to educate the patient about the need for integration of care and about their role as supporters of the generalist. Also, specialists will be expected to practice evidence-based decision-making and will be asked to educate patients and generalists about the strength of the evidence underlying their recommendations. Specialists who effectively meet the cost, quality, and service needs of the generalist will be successful.

In some areas of greater Minnesota, the change in roles may be less marked. Where generalists predominate, they will continue to have the orchestrating role. Because the "community of patients" is more clearly visible, shouldering responsibility for a population is not a new concept to generalists in greater Minnesota.

The future for specialists in those areas will depend on whether the supply of generalists is sufficient to meet the needs of the population. Where the supply of generalists is sufficient, specialists will be expected to make

themselves available to the generalists as supportive consultants. In areas of greater Minnesota where specialists settle randomly rather than in response to the need of the generalist, friction between generalists and specialists may result. Where the supply of generalists is insufficient to meet the population's need, however, the specialists will not only act as consultants, but may well assume responsibilities for patients' continuity of care at earlier stages of disease.

New Compensation Models

In the future, the compensation for owned and contracted primary care groups will be a budget model or a capitation model, adjusted for patient age, sex, and other factors. For example, patient acuity and quality of care and service may be considered. The future generalist will spend much time performing essential duties that currently are not billable, such as prevention, care coordination, and practice improvement. Already, many of the primary care groups that currently base compensation solely on production are adopting a payment method that combines a base salary with incentives for production, quality, satisfaction, and other features. In both the owned and the contracted HealthPartners delivery systems, generalists will be more difficult to recruit and retain than specialists.

For contracted specialists, future compensation will remain largely fee-for-service, based on HealthPartners' fee schedules. Except in a very few areas, capitation of specialty care is not likely.

Shifting Balance of Power

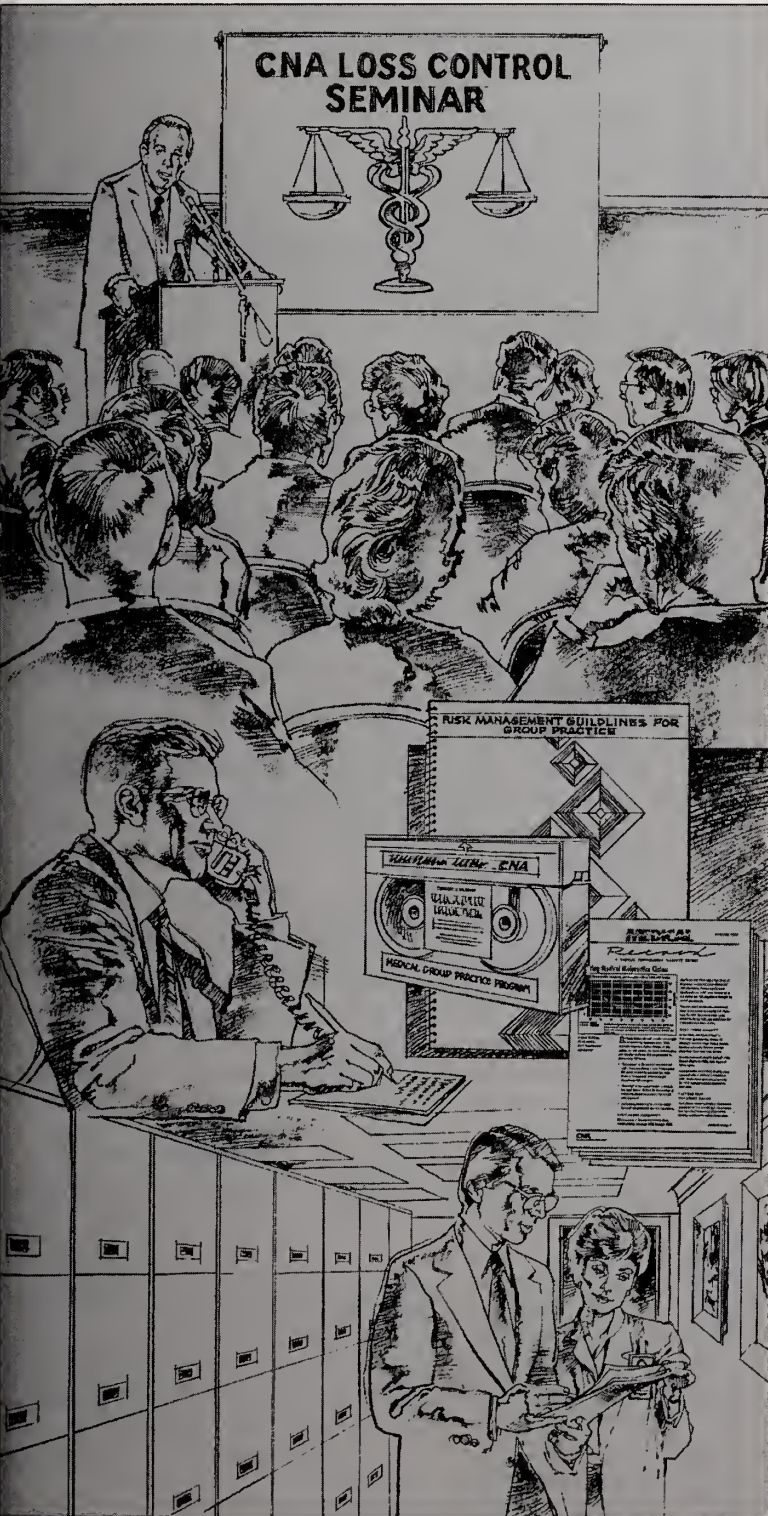
While change is always difficult, the change Minnesota's physicians now face is particularly challenging because it represents a shift in the relative balance of power between generalists and specialists. There is psychological distress resulting from a shift of influence, autonomy, and money. The degree to which we can satisfy the quality, service, and financial needs of the patients and payers will be the measures by which we judge the merits of these changes.

MM

Maureen Reed is medical director for MedCenters Health Plan. In this role, she provides leadership for medical policy, care management, quality improvement, physician relationships, and network development for medical groups affiliated with both MedCenters and Group Health. She also continues to practice internal medicine at Fremont Community Clinic part time. MedCenters and Group Health are part of the HealthPartners family of health care plans.

PREVENTIVE MEDICINE FROM CNA:

Risk management for the changing needs of your group practice.



At CNA, we believe that effective risk management is the cornerstone of any professional liability insurance program. That's why we have developed a broad and flexible risk management program to meet the changing needs of your medical group practice.

Our program helps protect your reputation and control your premium cost by showing you and your staff how to minimize your exposure to loss. We do this by offering regional educational seminars, video and journal reference materials, newsletters, telephone consultations and even on-site surveys. And, by attending one of our Medical Loss Control Seminars, you even receive a premium discount.

**CNA
MEDICAL
GROUP
PRACTICE
PROGRAM**

We have the expertise and resources to help your group practice now and as your needs change. For more information about medical group practice professional liability insurance from the CNA Insurance Companies, contact your local broker or:

The CNA Insurance Companies
Professional Liability Group, 19S
CNA Plaza
Chicago, IL 60685
(312) 822-5000

CNA

For All the Commitments You Make®

Program underwritten by property/casualty companies of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685. CNA is a registered service mark of the CNA Financial Corporation.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Forecasting Physician Workforce Requirements in Minnesota

Reinhard Priester, J.D., and Thomas E. Elliott, M.D.

ABSTRACT

The existing oversupply, specialty imbalance, and geographic maldistribution of clinicians are inconsistent with the goals of health system reform in Minnesota. Health professional workforce projections can help the private and public sectors make informed decisions to assure that the future supply of health professionals reasonably approximates requirements. Appropriate methodologies for projecting national health professional requirements, based on an existing HMO staffing patterns, should be applied to Minnesota. In the absence of workforce projections, a variety of assumptions about changes in Minnesota's health care system that will affect workforce supply and requirements can, nonetheless, be made. Limitations on the state's ability to influence the health professional workforce within its borders are noted.

The appropriate number, mix, and distribution of health care professionals can increase access to care, ensure quality of care, and help contain overall costs. However, several major imbalances currently exist in the health professional workforce. Basically, the workforce—in Minnesota and nationwide—is characterized by an “oversupply in the face of continued maldistribution and inappropriate specialty mix to meet the health needs of the [population].”¹ If current trends continue, each imbalance will worsen.

Much of the information on the current supply of clinicians in Minnesota comes from national sources, including the American Medical Association and federal agencies such as the Bureau of Health Professions (BHP) in the U.S. Department of Health and Human Services. However, these national data sources often do not have state-level information. Reliable projections of future workforce supply and demand are even harder to obtain. Only a few organizations (notably the BHP) make workforce projections, and they rarely account for state-specific factors that can significantly impact future workforce supply and requirements, such as the delivery and financing changes occurring in Min-

nesota's health care system.*

This paper builds on the efforts of the Workforce Subcommittee of the Minnesota Department of Health's Medical Education and Research Costs (MERC) study, a legislatively mandated study on the impact of health reform on medical education and research in Minnesota.² We first identify imbalances in the existing health professional workforce in Minnesota and nationwide. Next, we address workforce projections, of both supply and requirements, and then review recent national projections for future workforce requirements using existing staffing patterns in health maintenance organizations (HMOs). We conclude with a general discussion of the factors that may influence these projections and a call for further study of future clinician supply and requirements in Minnesota.

The ultimate goal of workforce projections is to help public policymakers, stakeholders in the health care market (including health plans, providers, and purchasers), and health professional students and practitioners make informed decisions to help assure that the future supply of clinicians (physicians, advanced practice nurses, and physician assistants) is compatible with the cost, quality,

*Information on the current supply of health professionals in Minnesota is rapidly improving. As part of the 1992 MinnesotaCare Act, the commissioner of health is required to develop and maintain a database of health services personnel. The Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) was charged with collecting information on health personnel in various professions, including physicians, dentists, nurses, and physician assistants. The information (on such factors as specialty, certification, work setting, hours, and location of practice) will be collected from each practitioner through the registration and licensure systems of the state health licensing boards. Data collection began in April 1993 from all practitioners licensed through the Board of Medical Practice, Board of Dentistry, and the Board of Nursing. The initial annual report on physicians was completed in 1994. The ORHPC reports contain no historical data but will provide invaluable baseline information on Minnesota's health professional workforce supply.

and access goals of a health care system.

Discussions about health professional workforce supply and demand usually focus on physicians. However, the number, specialty mix, and geographic distribution of other clinicians, including advanced practice nurses[†] and physician assistants, must also be considered. Health reform will require renewed emphasis on the appropriate supply of these non-physician providers (NPPs). Although it is unclear precisely how the respective roles of physicians and NPPs will change in the reformed system, NPPs are likely to increasingly substitute for physicians, and interdisciplinary teams will more often deliver health care.

WORKFORCE IMBALANCES

OVERALL SUPPLY

The United States has a growing oversupply of physicians. The number of nonfederal, active physicians in the United States has grown at a much faster rate than the general population, increasing the number of physicians per 100,000 population from 153 in 1970 to 267 in 1993. In the United States in 1993, there were 252 nonfederal, active M.D.s³ and, according to the American Osteopathic Association, 14.6 D.O.s per 100,000 population (personal communication, April 2, 1995). The physician supply in Minnesota has grown at a similar rate. Furthermore, Minnesota's physician-to-population ratio has been consistently higher than the national average. In 1993, Minnesota ranked 12th among states in the ratio of M.D.s per 100,000 population (257 per 100,000, compared with 252 per 100,000 nationwide).³

The physician supply will continue to grow. From 1995 to 2000, the number of physicians in Minnesota is projected to increase by nearly

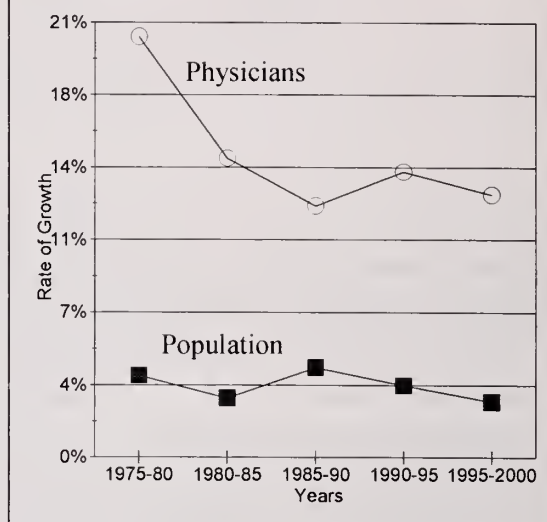
13%, and the general population less than 3%.⁴ Figure 1 shows the differential and projected differential between physician and general population growth for the years 1975 to 2000. State projections for physician supply beyond the year 2000 are not available. National projections to the year 2020, however, indicate that the difference between the growth rate in the general population (less than 1% per year) and the growth rate of physicians (approximately 1.5% per year) will raise the physician-to-population ratio in the United States by more than 25%.

SPECIALTY MIX

Whether the number of generalist physicians needs to be increased is still debated, but virtually everyone agrees that there are now too many specialists. (However, some authors have described national shortages of physicians in general surgery, adult and child psychiatry, preventive medicine, and generalists with geriatrics training.⁵) In 1992, about one-third of active physicians were generalists, down from one-half in the early 1960s. The relative number of specialists to generalists continues to grow. The Council on Graduate Medical Education reports that only 26% of 1987 medical school graduates completed generalist residency training and entered generalist practice; among 1989 graduates, this declined to 23%. In Minnesota, 36.5% of 1987 graduates from the University of Minnesota Medical School entered primary care, compared with 8.6% from Mayo Medical School.⁶

The Association of American Medical Colleges recently reported that the percentage of medical students graduating who are interested in pursuing generalist careers increased for the second year in a row, reversing a steady decline since the early 1980s. Nearly 23% of medical school graduates in 1994 plan to

Figure 1.
Rate of Growth Among Physicians
and General Population in Minnesota,
1975 - 2000



Source: AMA, BHPr, Minnesota Demographer.

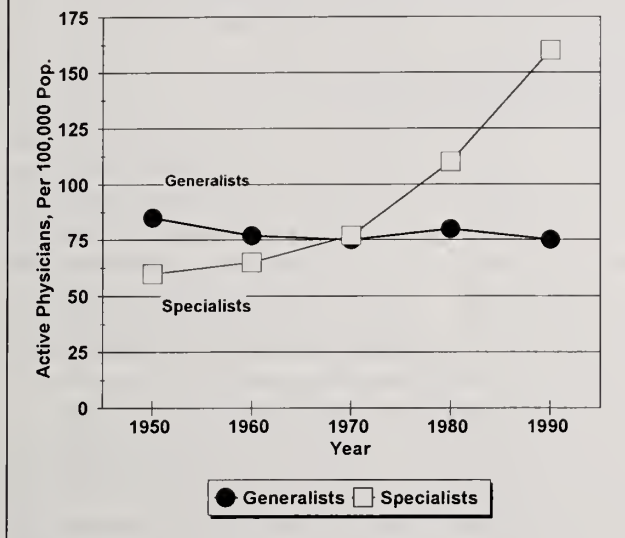
obtain only generalist certification, up from a low of 14.6% in 1992. It is unclear whether this two-year blip indicates a reversal of the long-term trend.

Many organizations have recommended increasing generalists to 50% of the physician workforce,⁷ a shift that would require dramatic changes in medical education. Because of the long training time for physicians and the number of trainees already in the pipeline, even if the percentage of resident physicians entering practice as generalists *immediately* increased to 50% (from less than 25% today), the percentage of generalists in the physician workforce would not reach 50% until the year 2040.⁸

But the generalist/specialist ratio should not be overemphasized.⁹ In a 1994 article, Richard Cooper argued that "primary care and specialty medicine are, to a large extent, independent variables." He notes that primary care needs are historical and somewhat constant, whereas specialty care needs have "evolved relatively recently and [are] determined principally by what science and technology make possible."¹⁰ The more important figures are the provider-to-population ratios for generalists and specialists. When measured in per capita terms, the gener-

†An advanced practice nurse is a nurse who has met special clinical practice requirements and has received training beyond the two to four years of higher education required for all RNs. Advanced practice nurses include nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists.

Figure 2.
Active Physicians Per 100,000
Population in U.S., 1950 - 1990



Source: Cooper 1994.¹⁰

alist workforce has remained relatively stable at 75 to 85 generalists (counting both practicing physicians and residents) per 100,000 population since 1950 (see Figure 2). The increased physician-to-population ratio observed over the past few decades is, therefore, almost solely attributable to the growing specialist-to-population ratio. According to Cooper, concerns about the specialty mix of physicians should focus on the steadily rising number (and provider-to-population ratio) of specialists, rather than the relative generalist/specialist ratio.

Of the 8,854 active physicians (not including residents) with at least one practice address in Minnesota in 1993, 3,510 (40%) were in the traditional primary care specialties (general and family practice, general internal medicine, and general pediatrics) and 5,344 (60%) in all other specialties.¹¹ Thus, the state had 78.6 generalist physicians and 118.2 specialist physicians per 100,000 population. Again excluding residents, the United States had 180 active, patient-care physicians per 100,000 population in 1992 (65.7 generalists and 114.4 specialists per 100,000 population).

GEOGRAPHIC MALDISTRIBUTION

The geographic maldistribution of

itself, solved the problem of underserved areas. The vast majority of additional physicians have established practice in urban areas. Overall, physician availability in rural counties is now less than one-third of the U.S. average.¹³

This geographic maldistribution is greatest for specialists but holds true for generalists as well. Family and general physicians have long provided the bulk of care in rural areas. But there are now too few of these generalists to replace retiring physicians. Other generalist physicians—general internists and general pediatricians—disproportionately favor metropolitan areas.¹⁴ In Minnesota, 65% of family and general practice physicians list their primary practice addresses in urban counties and 35% in rural counties—roughly approximating the urban-rural distribution of the state's overall population. In contrast, only 10% of Minnesota's internists and 7% of pediatricians practice in rural counties.¹¹

SKILLS AND COMPETENCIES

Clinicians will need new skills and competencies to function effectively in tomorrow's system. For example, the increased integration of Minnesota's health care system will mean that teams of health care professionals, rather than a single clinician, will

continues to leave many rural and inner-city communities underserved.⁵ Despite the extraordinary increase in physician supply, the number of areas with an inadequate supply of generalist clinicians, as well as the number of Americans without access to primary care services, has actually increased over the past decade.¹² Increasing the number of physicians in the United States has not, by

increasingly be used to provide medical services and manage a population's health. This requires greater interdependence of and cooperation among different types of clinicians. Managed care organizations—the cornerstone of Minnesota's reformed system—will require that health care professionals with different kinds and levels of expertise be combined into an "efficient and patient-responsive workforce"¹⁵ (see related article, page 15).

Adequate training in key areas that contribute to effective patient care is often lacking. The medical education system in Minnesota currently provides physicians and NPPs an excellent clinical and biomedical education. However, community health, epidemiology, preventive medicine, biomedical ethics, and health care policy are among the areas that receive relatively less attention, as do critical skills such as communication, interviewing techniques, decision analysis, and interdisciplinary collaboration.

The existing oversupply, specialty imbalance, and geographic maldistribution of clinicians are inappropriate for accessible, affordable, and quality care, and thus inconsistent with the goals of health system reform in Minnesota. Each of these workforce imbalances must be addressed. The restructured health care system in Minnesota is also placing new demands on clinicians. Until Minnesota rethinks and restructures medical education and practice, clinicians will be ill prepared for practice in this new system.¹⁶

WORKFORCE PROJECTIONS

Health professional workforce projections—of both supply and requirements—can help redress existing workforce imbalances. The term supply is relatively unambiguous, referring to the number of personnel working in a health setting. The term requirements, on the other hand, has different meanings. In this article, requirements is used as "an umbrella term encompassing all attempts to measure the need or demand" for health care professionals.¹⁷ Estimating the supply of clinicians can seem deceptively simple. For example, raw

counts of licensed professionals are relatively easy to obtain, e.g., through state licensing boards, but often significantly overestimate supply since a substantial, but frequently unknown, number of professionals are licensed by a state but no longer practice there. Minnesota is beginning to collect this information: of the 13,913 physicians licensed to practice in Minnesota, 3,151 are now known to no longer practice in the state, and more than 518 are retired and/or inactive.¹¹ Calculations of the future supply of clinicians are based on estimates of the current practitioner pool, projections for the number of new practitioners entering the pool, and projections for older practitioners leaving it.¹⁸

Projections of future health professional workforce requirements depend on historical data and trends as well as on changes in the health care delivery system, such as the growth of managed care and shift to outpatient care; demographic changes, such as population growth and aging; and advances in health care technology. Making accurate health workforce projections, a difficult task under ideal circumstances, becomes more daunting in a rapidly evolving health care system such as Minnesota's, which is undergoing major shifts in organizational arrangements, reimbursement, productivity, and other factors that affect workforce requirements. Models that can take account of such changes are needed for more reliable projections; it would be too risky to rely on simple extrapolations based on historical data.[‡] Some factors further complicate state-level projections; for example, although the continued exporting and, especially, importing of patients will influence future health professional workforce requirements in Minnesota, the precise impact is

uncertain.

There is no single, widely accepted approach to forecasting health care professional requirements. The most useful alternatives are needs-based models, demand-based models, and HMO models. Each has strengths and weaknesses. Needs-based models, estimating the number of health personnel that would be required to provide all care needed to maintain a healthy population, may overestimate the actual use of health care services.¹⁹ Empirical demand-based models estimate future personnel requirements by adjusting current utilization patterns and personnel productivity to future changes in the composition of the population and expected changes in the health care system. By basing future need on current use, demand-based models may underestimate personnel requirements for groups currently underserved by the health care system.²⁰ The continued growth of managed care has prompted several researchers to use staffing patterns of existing HMOs to predict future workforce requirements.

WORKFORCE PROJECTIONS USING HMO STAFFING PATTERNS

Despite considerable variation among HMOs' organizational and financing arrangements, they all typically use fewer physicians and far fewer specialists than the health care system overall. This difference is most pronounced among tightly run group- and staff-model HMOs, such as the Kaiser Permanente plans on the West Coast and Group Health, Inc., in Minnesota. HMOs also generally use more nonphysician providers, i.e., advanced practice nurses and physician assistants.

Inherent weaknesses in using HMO staffing patterns to make workforce projections are that HMO enrollees are not necessarily representative of the general population and their health care needs; HMOs may have significant "out-of-plan" care utilization; and only a few HMOs provide care in rural or inner-city areas. Also, certain specialists, such as psychiatrists, may be under-

utilized in HMOs.²¹ Thus, appropriate adjustments are needed before HMO staffing patterns can be applied more broadly. Furthermore, while there is good evidence that the staffing patterns of large, efficient HMOs reflect a cost-effective mix of personnel capable of providing high-quality, comprehensive health services to enrollees,²² there is no evidence "that the HMO [staffing] ratios represent the most beneficial use of resources to maximize the health of a given population."¹⁸ Nevertheless, the staffing patterns of HMOs can serve as a useful benchmark for establishing future workforce requirements.

The most recent and sophisticated analysis of health professional workforce requirements in a managed care-dominated system was published in July 1994 by Jonathan Weiner.²³ He first reviews the staffing patterns (in terms of FTE clinicians per 100,000 population) for several large staff- or group-model HMOs. Before extrapolating these to the entire U.S. populace, Weiner adjusts for possible bias in a number of variables, including demographic characteristics (since HMOs serve a population that is not representative of the entire population), productivity (for the purportedly greater productivity of physicians not working for staff- or group-model HMOs), and out-of-plan use. Weiner then uses the adjusted staffing levels to estimate workforce requirements for the year 2000, based on varying assumptions about the number of Americans who will be receiving care from different sectors of the health care system, including HMOs, other managed care organizations, and unmanaged fee-for-service. Comparing the forecasted requirements with projected workforce supply, Weiner concludes that:

- The overall supply of physicians in the United States will significantly outstrip requirements. This surplus is estimated to equal about 60 physicians per 100,000 population, or about 163,000 physicians overall, and is equivalent to about 30% of all patient care physicians.

- The primary care physician supply and requirements will be close to

‡Some commentators now suggest that the health care system is changing so rapidly that meaningful health professional workforce projections are no longer feasible. (Whitcomb M. Health professional needs for the future. Presentation at University of Minnesota, March 31, 1995.)

Table 1

A comparison of managed care staffing patterns and physician supply per 100,000 population

	Managed care staffing		1992 U.S. supply [‡]	1993 Minnesota supply [‡]
	Adjusted integrated network staffing level*	Group Health, Inc. 1994 staffing level [†]		
Total physicians	124.4	127.5	180.1	196.0
Generalist physicians—no. (%) [§]	55.9 (45%)	77.6 (60%)	65.7 (36%)	78.6 (40%)
Specialist physicians—no. (%)	68.5 (55%)	49.9 (40%)	114.4 (64%)	118.2 (60%)

*Data from Weiner 1994. Integrated networks include independent practice associations and network HMOs and other closed-panel integrated provider networks such as point-of-service plans.

†Does not include "hospital-based" physicians (radiologists, anesthesiologists, and pathologists).

‡Data from Minnesota Department of Health, 1994.

§Includes family physicians, general internists, and general pediatricians.

Data from Weiner reprinted with permission from JAMA 1994;272(3):222-30. ©1994 American Medical Association.

equilibrium. The supply of primary care M.D./D.O.s will be an estimated 7% to 18% above the desired requirements in the year 2000, depending on three different scenarios of the number of physicians trained.

- The United States will have a significant surplus of specialists. The overall supply is estimated to range from 61% to 67% above the requirement in the year 2000.²³

While striking, these conclusions are supported by previous analyses. More than a decade ago, the Graduate Medical Education National Advisory Committee (GMENAC), applying a needs-based forecasting methodology, predicted that by 1990 the United States would have a surplus of more than 70,000 physicians.¹⁹ Most of the oversupply would be in medical and surgical subspecialties; the supply and demand for generalists would be "in near balance." More recent reports by the Council on Graduate Medical Education, the Bureau of Health Professions, and the Physician Payment Review Commission also conclude that the nation's physician supply will exceed demand.^{7,20,24} For example, the BHP estimates that by the year 2000 the United States will have a surplus of 49,500 physicians, 86.7% of whom are expected to be specialists.

Driven by both market forces and public policy, Minnesota is rapidly moving toward a system dominated by competing managed care organizations. Managed care is used here to refer to the growing variety of alternative health care plans that combine the traditionally separate insurance and provider functions by integrating the delivery and financing of medical services, including HMOs as well as preferred provider organizations and point-of-service plans. Increasingly, managed care organizations take the form of integrated networks, which combine in one organization the different levels of care their enrollees need (vertical integration) or similar levels of care across communities or regions (horizontal integration). Changes in the health care market in the Twin Cities (and in Willmar, Duluth, and some other areas of outstate Minnesota), as well as recent MinnesotaCare laws supporting the development of integrated service networks (ISNs) and community integrated service networks (CISNs), point to continued growth of managed care in Minnesota and a trend toward integrated networks. It is widely assumed that existing managed care organizations in the state will serve as models for the new ISNs and CISNs.

Table 1 compares managed care staffing patterns with the existing physician supply in the United States and Minnesota. The first two columns of the table (Weiner's adjusted staffing patterns for integrated networks and existing staffing levels at Group Health, Inc.) may represent one end of the spectrum, while the last two columns represent the other end—with future workforce requirements falling somewhere in between. The large difference between the first and second set of columns indicates that significant changes will be needed to bring the future physician supply closer to requirements. The critical question is how Minnesota's health system reforms, with the anticipated expanded role for managed care organizations, will affect future health professional workforce requirements.

ASSUMPTIONS AFFECTING WORKFORCE PROJECTIONS

Health professional workforce projections for Minnesota do not yet exist; nonetheless, a variety of assumptions that will affect workforce supply and requirements can be made. While the true magnitude of the impact on workforce projections is often unknown, it is usually possible to

Table 2

Assumptions impacting workforce requirements and supply

	Impact on projections by type of provider			
	All physicians	Generalists	Specialists	NPPs*
Assumptions impacting requirements				
Assumptions about delivery system				
-growth in managed care enrollment	-	?	-	+
-universal coverage	+	+	+	+
-comprehensive USBS	+	+	+	+
-less generous USBS	-	-	-	-
-more Medicaid enrollees in managed care	-	?	-	?
Assumptions about population (demographics)				
-aging population	+	+	+	+
-increase in chronic diseases	+	+	+	+
-increase in minority populations	?	?	?	?
Assumptions about medical progress				
-new technology	?	?	+	?
Assumptions impacting supply				
Assumptions about health professionals				
-more women health professionals	-	-	-	?
-reduced productivity of physicians	-	-	-	+
-earlier retirement of physicians	-	-	-	+

+ = increase

- = decrease

? = impact unknown

*Nonphysician providers (physician assistants and advanced practice nurses)

predict whether these assumptions are likely to increase or decrease the supply or requirements for health care professionals. For some assumptions, however, even the direction of impact is unknown. Further, some assumptions about the future health care system may similarly affect the entire health professional workforce; others may affect specific types of clinicians differently. Table 2 shows the assumptions that will likely affect workforce projections. The magnitude and direction of the effects are highly speculative; the analysis below is our best guess of how the assumptions will affect the supply of and requirements for different types of health care professionals.

DELIVERY SYSTEM ASSUMPTIONS

The first four assumptions focus on major changes in the health care delivery system:

- Increasing the proportion of the population enrolled in managed care would likely decrease requirements for the total number of clinicians and significantly decrease the demand for specialists. Of all assumed changes, this one will have the greatest impact on workforce requirements in Minnesota.

- Expanding health care coverage to include everyone would likely increase the requirements for all types of health care professionals, since people who are uninsured generally use more health care services once they obtain insurance coverage.

- Defining a universal standard benefits set (USBS), establishing the set of health care services that all health plans must offer, may either increase or decrease requirements for clinicians. A very comprehensive USBS will likely increase the demand for all types of clinicians, whereas a

lean USBS (especially if it is less generous than a typical plan on the market today) will likely decrease demand.

- Increasing the ratio of Medicaid enrollees in managed care may decrease workforce requirements for specialists since most studies show a decline in the use of specialty services when Medicaid enrollees join managed care plans.²⁵

POPULATION-BASED ASSUMPTIONS

Changes in population characteristics will also affect workforce requirements. Both the continued aging of the population and the higher prevalence of chronic disease in the population will likely increase the need for clinicians, particularly for specialists.

TECHNOLOGY ASSUMPTIONS

Advances in diagnostic and therapeutic technologies, communication technologies, and biotechnology are likely to impact workforce requirements, although the direction and magnitude of the impact are largely unknown. Predicting specific technological advances that may increase or decrease the demand for clinicians is highly speculative. Once a technology comes on-line, its impact on the workforce is still often unclear. For example, telemedicine (which uses interactive television to facilitate communication over long distances between clinicians and between clinicians and patients) may reduce the demand for specialists in rural communities by allowing generalists in such communities to consult more easily with specialists in urban hospitals. For precisely the same reasons, however, telemedicine may make rural practice more attractive for some specialists. One relatively safe prediction

is that, overall, the explosion of new medical technologies will continue to increase requirements for specialists.

WORKFORCE ASSUMPTIONS

Several assumptions about the composition and productivity of the health professional workforce will affect future supply.

- Female physicians generally work fewer hours per week than their male counterparts, a difference that is greatest among younger physicians during their childbearing years. As the proportion of female physicians continues to grow (nationwide it has risen from 7.5% in 1970 to 18.1% in 1992), the supply of full-time equivalent physicians will decrease, even as the total number of physicians increases.

- The work effort, or productivity, of all practicing physicians also affects supply. Physicians overall are working fewer hours. Anecdotal evidence suggests that younger physicians increasingly want more time for leisure, family, and nonpatient care activities.

- As more physicians retire at earlier ages than before, take administrative or other positions with little or no patient-care responsibilities, and enter new "niche specialties," such as sports medicine and preventive health, the supply (of patient care physicians) will decrease.

DISCUSSION

Changes occurring in Minnesota's health care market may create a managed care-dominated system throughout the state like that already in place in the Twin Cities. Thus, it is instructive to apply to Minnesota Weiner's methodology for forecasting health professional workforce requirements.⁵ A number of adjustments must be made to account for differences between Minnesota and

the nation as a whole, including Minnesota's lower percentage of people without health insurance, higher percentage of Medicaid enrollees already in managed care plans, older but healthier population, and larger proportion of physicians in teaching, research, and other positions with little or no direct patient care activities. These differences are relatively small; thus, their effect on workforce projections for Minnesota relative to Weiner's national projections, although important, would not be large.

The above differences would likely be overshadowed by two factors that differentiate Minnesota from the rest of the nation. First, the state already has a highly developed managed care market. The proportion of Minnesota's population that will be enrolled in managed care organizations by the year 2000 is larger than Weiner's national projections, which assume that at least 40% and as many as 55% of Americans will be enrolled in some form of managed care plan by the end of this decade. In Minnesota, 64% of the state's population of 4.5 million is already enrolled in managed care (including enrollees in self-insured plans where health services are delivered by a managed care plan).²⁶ A reasonable assumption for Minnesota, therefore, is that by the year 2000 at least 70% and as many as 90% of Minnesotans will be enrolled in a managed care organization.

Second, Minnesota is a net patient-care exporter. A significant portion of patients seen at Minnesota's health care facilities are from out-of-state (for example, about 46% of the 1.5 million annual patient visits to Mayo facilities in Rochester are from out-of-state).²⁷ However, in northwest and southwest Minnesota, many Minnesota residents seek care in adjoining states. These two factors have opposite effects—the first will increase requirements for health professionals, and the second will decrease requirements. The factors' precise impact remains conjectural, however, and further work is needed before reliable projections can be developed.

Once workforce projections are

obtained, a broad range of strategies are available to deal with workforce imbalances, including 1) providing continuing medical education for specialists to update their primary care skills (retraining); 2) changing the recruitment, admission, and retention policies of medical schools and graduate medical education programs; 3) reforming the medical and graduate medical education curricula to train physicians who can practice in a new health care system and meet the needs of patients and populations; and 4) improving the practice environment—especially in underserved areas. But several factors will mute the impact of any of these strategies on the health professional workforce in Minnesota, including the following:

- The state's permeable borders permit considerable in- and out-migration of medical residents and practicing physicians. For example, 51% of physicians trained in Minnesota GME programs leave the state to establish practice elsewhere.²⁸

- The long training period (which can exceed 10 years for a postbaccalaureate degree for some subspecialists) means that any marketplace changes or regulatory initiatives implemented today will not appreciably affect the physician workforce for another 10 to 15 years. Also, changing medical school and postgraduate medical education curricula alone takes five or more years. Modifying admission criteria or reducing medical school enrollment can take a similar amount of time. Thus, the imbalances in Minnesota's health professional workforce described above are unavoidable for the next 10 to 15 years.

- The federal government will likely remain the largest single source of funding for graduate medical education and, thus, will retain its significant influence on the number and specialty mix of positions in the nation's graduate medical education system. With the recent failure of national health reform, however, changes in national policies are needed to allow states to be more effective in reforming the health professional workforce. If these workforce issues remain a national issue, at the least,

§Note that the Department of Health's MERC Workforce Subcommittee felt it was not able to comprehensively assess Weiner's methodology and, thus, did not recommend applying it to Minnesota at this time.

states should provide expertise concerning local needs to inform national policy on medical education.[¶]

CONCLUSION

Health system reform is having a major impact on the health professional workforce in Minnesota. Yet recent discussions on health professional workforce issues have taken place mostly on the national level. This paper is meant to engender interest and discourse on health professional workforce issues as they apply to Minnesota. We have attempted to demonstrate the effect of market changes and policy initiatives on the health professional workforce in Minnesota, now and in the near future. We recommend that national projections be adapted to fit Minnesota, with adjustments made as needed, to inform decisions in the private and public sectors affecting the health professional workforce. Even without projecting specific numbers for clinician supply and requirements, we can conclude with confidence that Minnesota has a surplus of physicians—mostly specialists—that will worsen over the next 10 to 15 years. The health professional workforce issues presented here are crucially important to physicians, other health care providers, the medical education system, the state, payers of health care, and—most important—to patients and Minnesota citizens. **MM**

The opinions expressed in this paper are those of the authors and do not necessarily reflect the opinions of the Minnesota Department of Health.

Reinhard Priester is an independent health policy consultant in Minneapolis. When the work reported in this paper was done, he was a research scientist with the Minnesota Department of Health and staffed the department's Medical Education and Research Costs (MERC) Advisory

Task Force. Thomas Elliott is director of medical education and research with the Duluth Clinic. When the work reported in this paper was done, he was a member of the MERC Task Force and chair of its Workforce Subcommittee.

REFERENCES

1. Bazell C, Politzer RM, Rivo ML. Health care reform and primary care: a mandate for graduate medical education reform. *J Fam Pract* 1994;38(5):530-3.
2. Minn. Stat. § 62J.045 (1993); Laws of Minnesota, Ch. 625, Art. 5, § 10 (1994).
3. American Medical Association. Physician characteristics and distribution in the U.S. Chicago: American Medical Association, 1994.
4. Minnesota State Demographer's Office. A changing population: the next 30 years. St. Paul, Minnesota: Minnesota Planning, 1993.
5. Rivo ML, Satcher D. Improving access to health care through physician workforce reform: directions for the 21st century. *JAMA* 1993;270(9):1074-8.
6. Association of American Medical Colleges. 1992 Institutional goals ranking report. Washington, D.C.: Association of American Medical Colleges, 1993.
7. Council on Graduate Medical Education. Third report: improving access to health care through physician workforce reform: directions for the 21st century. Rockville, Maryland: Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services, 1992.
8. Kindig DA, Cultice JM, Mullan FH. The elusive generalist physician: can we reach a 50% goal? *JAMA* 1993;270(9):1069-73.
9. Whitcomb ME. A cross-national comparison of generalist physician workforce data: evidence for U.S. supply adequacy. *JAMA* 1995;274(9):692-5.
10. Cooper RA. Seeking a balanced physician workforce for the 21st century. *JAMA* 1994;272(9):680-7.
11. Minnesota Department of Health. A summary of practice related data, Minnesota physicians, April 1993-March 1994. Minneapolis: Minnesota Department of Health, Office of Rural Health, 1994.
12. Council on Graduate Medical Education. Fourth report: recommendations to improve access to health care through physician workforce reform. Rockville, Maryland: Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services, 1994.
13. Shugars DA, O'Neil EH, Bader JD, eds. Healthy America: practitioners for 2005. Durham, North Carolina: Pew Health Professions Commission, 1991.
14. Barnett PG, Midtling JE. Public policy and the supply of primary care physicians. *JAMA* 1989;262(20):2864-8.
15. Hadley J. Workforce policies: physicians and nurses in healthcare reform. *Inquiry* 1994;31(3):342-5.
16. LeRoy LB. Meeting the challenge: a health workforce prepared for the future. *Inquiry* 1994;31(3):334-7.
17. Feil EC, Welch HG, Fisher ES. Why estimates of physician supply and requirements disagree. *JAMA* 1993;269(20):2659-63.
18. Schroeder SA. Managing the U.S. health care workforce: creating policy amidst uncertainty. *Inquiry* 1994;28(3):266-75.
19. Graduate Medical Education National Advisory Committee. The report of the Graduate Medical Education National Advisory Committee. Hyattsville, Maryland: Health Resources Administration, Department of Health and Human Services, 1980.
20. Bureau of Health Professions. Health personnel in the United States: eighth report to Congress, 1991. Rockville, Maryland: Bureau of Health Professions, Health Resources and Services Administration, Public Health Service, Department of Health and Human Services, 1992. (DHHS Report No. HRS-P-OD-92-1.)
21. Veenhuis PE. Forecasting physician workforce requirements. [Letter]. *JAMA* 1995;273(2):112-3.
22. Wennberg JE, Goodman DC, Nease RF, Kelle RB. Finding equilibrium in U.S. physician supply. *Health Aff* 1993 summer:89-103.
23. Weiner J. Forecasting the effects of health reform on U.S. physician workforce requirement: evidence from HMO staffing patterns. *JAMA* 1994;272(3):222-30.
24. Physician Payment Review Commission. Reforming graduate medical education. In: Physician Payment Review Commission. 1993 annual report to Congress. Washington, D.C.: Physician Payment Review Commission, 1993.
25. The Kaiser Commission on the Future of Medicaid. Medicaid and managed care: lessons from the literature. Menlo Park, California: Henry J. Kaiser Family Foundation, 1995.
26. Baumgarten A. 1994 Minnesota Managed Care Review. Minneapolis: Allan Baumgarten, 1994.
27. Gold M, Chu K. Financing of academic medical centers and graduate medical education under competitive systems with managed care. Washington, D.C.: Mathematica Policy Research, Inc., 1994.
28. Seifer SD, Vranizan K, Grumbach K. Graduate medical education and physician practice location: implications for physician workforce policy. *JAMA* 1995;274(9):685-91.

[¶]An important issue not addressed in this paper but integral to workforce issues is appropriate minority representation. There are still too few minority physicians in the current workforce. Incentives provided by both the marketplace and the state are needed to address these problems.

Recruitment and Retention of Family Physicians

Byron J. Crouse, M.D.

ABSTRACT

This study investigates the factors family physicians report as influencing their recruitment and retention. Fifty family physicians who completed their residency training at the Duluth Family Practice Residency received surveys one year and three years after entering practice. Spouses' preferences were most important at the time of recruitment, while children's issues were more influential at the time of the retention survey. The diversity of the higher-ranked variables indicates the multifactorial nature of decisions to settle and maintain practice in a community.

Communities and facilities that are recruiting family physicians need to work together. The community's educational system and needs of the spouse must be directly addressed for effective recruitment and retention. Income is important to retention, even though individuals ranked it low as a variable.

Demand for primary care physicians is growing. A Minnesota Hospital Association survey conducted in 1989 revealed a need in Minnesota for 200 family physicians. A recent survey conducted by the Minnesota Center for Rural Health revealed that this number now exceeds 290. With health system reform underway, the importance of primary care physicians is being recognized. The American Academy of Family Physicians (AAFP) recommends that 50% of the primary care physicians in this country should be family physicians. Compounded by a changing health care system, the demand for family physicians will continue to grow.

A number of studies have pinpointed factors important to successful physician recruitment, such as income guarantees and active participation between physicians and hospital administration.¹ Studies on retention show that physicians leave practices for a variety of factors, such as economic reasons, physician relations, and practice arrangements.²

Few studies have looked at factors influencing both the recruitment and retention of family physicians, and most studies consider all specialties in aggregate. This study's goal was to evaluate a cohort of family physicians twice (one and three years into practice) to identify the factors they consider influential in their recruitment and retention.

METHODS

Beginning in 1982, family physicians who had completed their family practice residency training at the Duluth Family Practice Residency Program were sent questionnaires pertaining to recruitment one year after entering practice. The survey contained 31 questions about what influenced

the physicians' practice site selection. These items asked about professional issues, hospital issues, community acceptance of family practice, community characteristics, recreational and cultural opportunities, and family needs. The respondents evaluated these factors on a 6-point Likert scale, with 1 indicating no influence and 6 indicating the variable played a major role in practice selection. The survey solicited other information from the respondents with open-ended questions.

Two years later, a questionnaire relating to retention was sent. This time, the physicians were asked to evaluate the same factors, based on the influence these factors had on their decision to stay in their current practice site or to relocate. Again, the physicians were asked to list any other factors that influenced their decision. Demographic information was obtained at the time of both surveys, including marital status, presence of children in the family, and community size.

The study analyzed recruitment and retention factors, controlling for gender, marital status, parenthood, and relocation of practice site. Multiple regression analysis identified factors from the recruitment survey that were associated with relocation and created a model to predict who would or would not relocate. Discriminate analysis was performed to determine the strength of these factors in predicting relocation.

RESULTS

Of the 50 physicians eligible to participate, 46 completed both surveys. The respondents consisted of 34 male and 12 female physicians. At the time of the recruitment questionnaire, 41 were married and 22 had children. At the time of the retention survey,

Table 1

Highest ranked variables influencing recruitment one year after residency

	Mean score	Standard deviation
Spouse's preference	4.80	1.39
Married	4.97	1.14
Single*	3.00	2.45
Recreation	4.80	1.25
Community acceptance of family practice	4.66	0.97
Hospital quality	4.52	0.90
Group practice	4.39	1.42
Size of community	4.34	1.48
Children's lifestyle	4.27	1.65
Children	4.77	1.34
No children*	3.77	1.80

Based on a Likert scale where 1=no influence and 6=a major influence.

*Single respondents or those with no children may be anticipating the impact of a change in family composition and may have ranked the variables' influence as greater than 1.

44 were married, 35 had children, and 17 (37%) had relocated.

The variables ranked highest in influencing recruitment are reported in Table 1. The top four were spouse's preferences if the physician was married, recreational opportunities, community acceptance of family practice, and the quality of the hospital. Of interest, income ranked 18th of 31 variables. Table 2 lists factors identified as most important three years after residency training, at the time of the retention survey. Community acceptance of family practice was the highest-ranked variable, and the quality of children's lifestyle was third.

The factors that changed in importance were in the three categories of professional needs, community factors, and family needs (Table 3). The importance of children in the family became apparent, with both the quality of the children's lifestyle and their educational opportunities

spouse's educational and employment opportunities decreased. This is consistent with changing family characteristics at this time in most physicians' careers.

The survey revealed very few gender-related differences. At the time of the recruitment survey, female physicians rated spouse employment significantly higher than did male physicians (4.91 vs. 3.42, $t=2.31$, $p=0.03$). The degree of this difference decreased at the time of the retention survey. Female physicians placed more importance on paramedical staff than did the male physicians at the time of both the recruitment and retention surveys. Otherwise, men and women ranked the factors essentially the same. Male and female respondents ranked income and the length of work week identically at the time of both questionnaires. They also gave the same rankings to the importance of children's lifestyle and to children's

Table 2

Highest ranked variable influencing retention three years after residency

	Mean score	Standard deviation
Community acceptance of family practice	5.14	0.81
Hospital quality	5.07	0.96
Children's lifestyle	5.00	1.31
Children	5.32	0.75
No children*	2.00	2.00
Recreation	4.95	1.02
Spouse's preference	4.79	1.44
Married	4.88	1.32
Single	1.00	—

Based on a a Likert scale where 1=no influence and 6=a major influence.

*Respondents with no children may be anticipating the impact of having children in the future and may have ranked the variable's influence as greater than 1.

increasing in importance. At the same time, the importance of the

educational opportunities.

Thirty-seven percent of respondents relocated during the three years of this study. When relocating, 47% moved to a community of similar size, 29% moved to a smaller community, and 24% moved to a larger community. Table 4 shows how the recruitment factors were ranked differently by physicians who remained at their original practice setting and those who relocated. Physicians who did not later relocate ranked children's educational opportunities and the quality of children's lifestyle higher than did those who relocated. Although income was never identified as a high-ranking variable, its ranking did differ significantly between those who remained in their same practice settings and those who relocated. Of those who relocated, 24% (4 of 17) experienced a change in marital status. Significantly, all who had a change in marital status relocated ($X^2=6.77$, $df=1$, $p=0.009$). There were no statistically significant differences between the 33% of female physicians who relocated and

the 38% of male physicians who relocated.

Multiple regression analysis revealed children's educational opportunities, income, presence of children in the family, proximity to extended family, and gender were significant independent variables when relocation was used as the dependent variable. Using these factors, discriminate analysis correctly predicted 87.5% of those physicians who relocated. It also correctly identified 92.9% of the physicians who remained in a stable practice. Combining the five factors correctly predicted more than 90% of the time who relocated and who remained in their practice site.

DISCUSSION

PAST RESEARCH

Factors important to successful recruitment have been under study for many years. In the 1970s, researchers concluded that additional incentives and efforts were needed to recruit family physicians to rural communities.¹ Variables identified as important included income guarantees and active participation between physicians and hospital administration. Initially, recruitment issues were emphasized. Korman and Feldman, however, argued that retention was equally important and found that continued support from other physicians and the community at large improved retention.³

Further studies of recruitment and retention were undertaken in the 1980s, when health maintenance organizations were becoming more prevalent. HMO administrators found the recruitment of family physicians difficult, in part because their competition, clinics with fee-for-service payers, offered higher salaries. In response, HMOs began "training their own."⁴ An early example of this was Kaiser Permanente Medical Centers in Northern California sponsoring residency programs in internal medicine, pediatrics, and obstetrics and gynecology to help meet their physician needs.

At this time, Lichtenstein, in a review article on physician satisfaction and retention, determined that physician satisfaction is the highest

among physicians in smaller groups. He found that physicians left practices because of concerns related to a variety of factors, including (in decreasing order of importance) economic reasons, physician relations, practice arrangements, "other factors," environmental factors, clinical goals and plans, and personal health reasons. He found higher retention among specialty physicians who were older, higher paid, black, and employed 15 to 30 hours per week.²

Recently, more information has been published on recruitment and retention issues involving government clinics, such as the National Health Service Corps.⁵⁻⁸ Again, issues of professional and personal importance were identified as major factors in recruitment and

retention. Physicians identified poor pay, poor benefits, poor working conditions, and poor management as reasons they left community health centers.⁵ Others identified the importance of continued cooperative ef-

Table 3

Variables with greatest change between recruitment and retention surveys

Increased in ranking

Need for family physicians	+1.04
Medical consultants present	+0.80
Quality of children's lifestyle	+0.73
Children's educational opportunities	+0.68

Decreased in ranking

Spouse's educational opportunities	-0.38
Spouse's employment opportunities	-0.32
Commitments to community (loan repayment or other obligation to the community)	-0.28

Based on a Likert scale where 1=no influence and 6=a major influence.

Table 4

Difference in rankings between those in a stable practice site and those who relocated

	Relocated	Stable practice	t	p
Children's education	2.50	4.36	4.08	<0.01
Loan availability	1.31	2.36	3.94	<0.01
Income	2.38	3.50	3.20	<0.01
Children's lifestyle	3.31	4.82	2.76	0.01
Proximity to hospital	3.38	4.36	2.39	0.02
Length of work week	3.06	3.93	2.26	0.03
Continuing medical education	2.63	3.50	2.21	0.03
Group practice	3.81	4.71	2.11	0.04
Quality of housing	2.00	2.86	2.10	0.04

Based on a Likert scale where 1=no influence and 6=a major influence.

forts between physicians in the communities to effect efficient recruitment and retention.⁶

RECRUITMENT AND RETENTION SURVEY

The survey described here identified professional, personal/family, and community factors as important in both recruitment and retention of family physicians. The diversity of these factors reveals the multifactorial nature affecting decisions about where to practice. The importance of most factors remained stable between the recruitment and retention surveys; however, a number of issues did change from the time of recruitment to the time of retention. While the most highly ranked variable at the time of recruitment was spouse's preference, the importance of children's issues became far more important at the time of retention.

Other researchers have found that some of a community's appealing characteristics for incoming physicians may become its weaknesses over time.⁶ This may reflect changes as the physician and family mature. For example, a community that is somewhat remote and quiet and that provides recreational opportunities may not be as appealing when the physician has children and their education and lifestyle must be taken into consideration. A quality educational system and children's opportunities are very important for a community to retain physicians.

Interestingly, at the time of both the recruitment and retention surveys, physicians ranked income in the lower half of variables. However, the analysis identified it as a distinguishing variable between those who remained in their practice setting and those who relocated. Individually, both male and female physicians minimized the importance of income. Nonetheless, income appears to have a significant influence on stability in a practice setting. The small difference between starting salaries may decrease the importance of this variable at the time of recruitment. However, as an individual variable, it was still ranked low at the time of retention. Pathman cautions that introspective causal reports and beliefs

may not accurately explain behavior.⁹ Factors that physicians report as important and the actual factors that determine their decisions to stay or relocate may not be the same. In the current study, this appeared to be the case for income and proximity to extended family.

Change in marital status had a strong impact on relocation. While the number of physicians who fit this category was small, *all* physicians who experienced a change in marital status moved to a new practice site. The survey did not determine cause and effect. It is unclear whether the move was a result of the change in marital status, or vice versa.

STUDY LIMITATIONS

The study, which analyzed the factors physicians believe influence recruitment and retention, has limitations. Spouses' beliefs may be different from the respondents' and worth evaluating. Deciding where to practice and whether to stay clearly involves many factors, and more information about the spouses' and families' input is needed.

The respondents were all from one family practice residency program, which may promote bias in the population. All physicians surveyed had selected this particular program, which has a focus and reputation for rural residency training; consequently, the survey may not represent a random sampling of physicians. The physicians in the study, however, did select practice sites throughout the country and continued to practice throughout the United States. Therefore, the results may apply to physicians outside the Upper Midwest.

The survey dealt with physicians completing a family practice residency and going immediately into practice. It did not directly assess issues involving recruitment and retention of physicians who relocate after practicing for longer periods of time. The retention survey was completed by physicians who had been in practice for three years, who indicated that their changing families influenced retention. Other factors may become more important over time and have a major influence on longer-term retention.

CONCLUSION

In the recruiting process, the physician group and the community need to work together to address the needs of the incoming physician, his or her spouse, and the family. The quality of the hospital and the physicians is important in recruitment, as is the quality of the community's educational system. Any change in marital status results in a high likelihood of physician relocation. Although physicians did not identify income as an important or high-ranking variable for either recruitment or retention, it was, in fact, important in predicting retention. Little difference was found in the variables assessed between male and female physicians at the time of recruitment or retention. MM

Byron Crouse is an associate professor and head of the Department of Family Medicine, School of Medicine, at the University of Minnesota-Duluth.

REFERENCES

1. Hamm M. How to recruit and retain physicians for rural hospitals. *Hosp Med Staff* 1977;6(10):1-7.
2. Lichtenstein RL. The job satisfaction and retention of physicians in organized settings: a literature review. *Med Care Rev* 1984;41(3):139-79.
3. Korman L, Feldman HA. A study of the recruitment of physicians into three northern New York counties. *J Med Educ* 1977;52(April):308-15.
4. Fink R. HMOs and physician recruiting: a survey of problems and methods among group practice plans. *Public Health Rep* 1981;96(6):568-73.
5. Stokoe U. Physician recruitment and retention in community health centers. *J Amb Care Man* 1992;15(1):21-8.
6. Conte SJ, Imershein AW, Magill MK. Rural community and physician perspectives on resource factors affecting physician retention. *J Rural Health* 1992;8(3):185-96.
7. Pathman DE, Konrad TR, Ricketts TC. The comparative retention of National Health Service Corps and other rural physicians. *JAMA* 1992;268(12):1552-8.
8. Verby JE. Improving the supply of physicians in rural areas. *JAMA* 1992;268(12):1597-8.
9. Pathman DE, Agnew CR. Querying physicians' beliefs in career choice studies: the limitations of introspective causal reports. *Fam Med* 1993;25(3):203-7.

ANNOUNCEMENTS

• • • • •

MMA OFFERS CODING WORKSHOPS

The Minnesota Medical Association announces its Fall 1995 Basic and Advanced CPT/ICD-9 Coding and Reimbursement Management Workshops. The all-day workshops will be held October 5-6 in Duluth, October 9-10 in Mankato, November 6-7 in St. Cloud, and November 14-15 in St. Paul. The registration fee is \$175 for the first registrant from a clinic, \$150 for each subsequent registrant, and \$300 if the same person registers for both the basic and advanced workshops. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

• • •

MINNESOTA HOSPITAL AND HEALTHCARE PARTNERSHIP NAMES ROGNESS PRESIDENT

The board of directors of the newly formed Minnesota Hospital and Healthcare Partnership has named Stephen Rogness as president. The MHHP was formed August 24 by the merger of the Minnesota Hospital Association and the Metropolitan Healthcare Council. Rogness served as president of the Minnesota Hospital Association for 26 years and played a key role in the merger of MHA and MHC.

• • •

CALL THE AMA HOTLINE

Legislation before Congress changes rapidly. Call the AMA Grassroots Hotline for an update on the current action on Capitol Hill. The toll free number is 800/833-6354.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Discusses Medicare With Minnesota Delegation

During the recent congressional break, Minnesota Medical Association leaders and staff held discussions on Medicare with U.S. Sens. Rod Grams, R, and Paul Wellstone, DFL, and met with Minnesota Reps. Gil Gutknecht, R; David Minge, DFL; Jim Ramstad, R; Martin Sabo, DFL; and Collin Peterson, DFL. The MMA urged the congressional delegation to support the following principles for Medicare reform:

- Maintain the option for seniors to remain in a traditional Medicare program.
 - Give Medicare recipients the same choice of delivery systems as other insured individuals. Delivery system choices should include indemnity insurers, HMOs, PPOs, and provider-directed organizations.
 - Eliminate unfair variations in Medicare payment based upon location so that Minnesota and other low-cost states are no longer penalized for their efficiency. Base geographic differences in Medicare payment only on appropriate data that reflect the true differences in the resource costs of maintaining a medical practice.
 - Shift funding of graduate medical education from reliance on the Medicare system to a system that includes all payers, public and private.
- Both Republican and DFL lawmakers expressed support for the MMA positions on geographic equity in payment and for broad-based funding of graduate medical education.

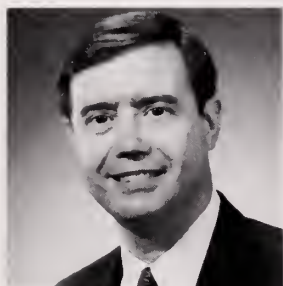
The delegation's clear message was that Medicare cuts are inevita-

ble, and only the extent and timing of the cuts are in doubt. Wellstone vigorously opposes the sharp reductions in Medicare growth proposed by the Republicans and believes that a good deal of negotiation will have to take place before any agreement on Medicare is reached.

According to Ramstad, Republican House Speaker Newt Gingrich is well aware of the political risk of running afoul of powerful senior voters, but he is extremely serious about passing a bill this session. Ramstad predicts the real debate will take place in the House Ways and Means Committee, where he serves, and in the Senate Finance Committee. By the time the bill reaches the House and Senate, Ramstad thinks the vote will be up-or-down.

Peterson told the MMA that because the Republicans need the conservative or "Blue Dog" Democrats to override a presidential veto, Republicans have an incentive to compromise with the Blue Dogs. Peterson, who along with Minge counts himself among the Blue Dogs, favors expanding choice for Medicare recipients, introducing more managed care arrangements and means testing, as well as preserving the traditional Medicare program as an option. These are all elements of the AMA plan for transforming Medicare. Peterson believes that cuts in growth will be less drastic than the \$270 billion the Republicans want.

In addition to discussing Medicare issues, the MMA urged the delegation to support anti-violence and anti-smoking legislation. • • • • •



Viewpoint

...

Timothy J. Crimmins, M.D.
Chair, MMA Board of Trustees

Starting Practice in 2005? How Will You Get GME?

The first sounds of the ax falling on federal funding for graduate medical education (GME) are already being heard in Minnesota. Recently, the University of Minnesota Academic Health Center announced that more than 300 hospital residency positions will be cut during the next two years. Federal funding reductions for residency programs and shrinking revenues from patient care make it impossible for the university to afford its current number of residents.

Traditionally, Medicare has been the single largest explicit source of funding for GME, but that source is rapidly disappearing. Medicare's support for resident education at the university was cut from \$17.4 million in 1994 to \$16.4 million in 1995. This may be only the beginning.

In an effort to cut the deficit, Congress is considering major reductions in GME funding. Under some proposals, GME payments would be reduced by 50 percent. Such severe cuts could have a devastating effect on residency education in Minnesota. The University of Minnesota estimates that it costs about \$103,000 a year to educate one resident physician. In the past, Medicare has provided Minnesota roughly \$82,000 per eligible resident.

In addition to the loss of Medicare funds, the other major source of GME funding—patient care dollars

—has been reduced as well. Traditionally, teaching hospitals have obtained money from the private sector by charging higher prices to cover their education costs. In Minnesota's increasingly competitive health care environment, however, private payers are no longer willing to pay these higher charges. Furthermore, as Minnesota develops competing medical service systems, there are fewer referrals "out of system" to teaching hospitals.

It is critical to find alternative funding for GME and at the same time to review the structure of resident education. There have been a number of criticisms of the current system. Because Medicare pays for GME only in teaching hospitals, the emphasis of resident education has been on inpatient rather than outpatient care. With the growing trend toward outpatient management, physicians also need to develop skills in ambulatory care and disease prevention. Another drawback is that the patients and the illnesses residents see in large teaching hospitals may not be typical of those they will encounter in their practice. In teaching hospitals, there is more critical and specialty care and less general medical care.

In reviewing the current GME system, the following questions should be addressed: Where should resident physicians be trained? Are we training the right number of res-

idents? Do we educate the right mix of physicians in all specialties including primary care specialties? How should training sites be distributed throughout the country?

Planning graduate medical education is a challenging task. It takes physicians eight to 10 years to go through the educational pipeline, and it is difficult to project the country's medical needs so far in advance. Most physicians would agree this is a national issue that requires federal solutions. Because physicians are often trained in one state and practice in another, GME should not be primarily the states' responsibility.

A number of ideas are under consideration. The AMA has proposed that a national public-private planning commission be set up to make recommendations about workforce needs and GME funding. This group would consider such things as specialty mix, geographic distribution, and appropriate training for the emerging health system. There is growing support for reducing the number of residencies, which currently exceeds the number of students graduating from U.S. medical schools. The AMA recommends that first-year federally funded residency positions throughout the nation be limited to 110 percent of the number of graduates from U.S. medical schools. Another idea under consideration is to allow accredited residency training programs in non-hospital settings such as nursing homes or ambulatory clinics to compete for residents and for federal dollars. In addition, the AMA has proposed an all-payer GME funding pool.

The MMA task force on medical education has been considering the problems facing GME and proposed solutions and is developing recommendations to present to the MMA Board of Trustees. The MMA is also urging the Minnesota congressional delegation to develop an alternative federal funding source for GME. Funding and planning for GME are essential if we are to continue to educate excellent physicians and preserve our high quality of health care.

.....

Congress Considers Cuts in Medicare GME Spending

Both the U.S. House of Representatives and the Senate are considering cuts in the direct and indirect formulas for Medicare graduate medical education payment. Under some proposals, GME payments would be slashed 50 percent, which could result in significant cuts in faculty and specialty program slots, decreased pay for resident physicians, and an overall drop in the quality of education for residents and health care services for patients.

There have been significant improvements, however, in the most detailed GME proposal in the House, introduced by Rep. Nancy Johnson, R-Conn. After the American Medical Association expressed strong opposition to her original draft, Johnson revised her bill to address many, but not all, of the AMA's concerns. In one improvement, proposed reductions in residency positions were made less drastic and stretched over a longer period of time. In Johnson's revised bill, by the year 2000 the number of Medicare-funded residency positions would be limited to 110 percent of the number of graduates from U.S. medical schools.

Other proposals in Johnson's bill include the following: set up a joint Prospective Payment Assessment Commission/Physician Payment Review Commission study group to study the current source and distribution of Medicare financing and recommend alternatives for a broad-based all-payer financing mechanism; allow federal reimbursement to training sites other than hospital-based programs; ensure proper reimbursement of medical education costs by managed care contracts; and gradually shift funding for subspecialty and fellowship training to centers of excellence or high-quality programs designated by specialties.

The AMA still has a number of concerns about this legislation. For instance, no criteria currently exist that would enable the government to appropriately rank centers of excellence. The AMA also wants private-sector experts to be included on any commission that does long-range planning or makes payment recommendations. As the congressional debate continues, the AMA warns that GME is an inviting target for budget cutters. ♦ ♦ ♦ ♦ ♦

Maintain Medicaid Safety Net, MMA Urges

The Minnesota Medical Association wrote to the Minnesota congressional delegation and urged members to ensure that under any federal restructuring plan, Medicaid will still provide a health care safety net for the nation's most vulnerable people.

In order to reach budgetary targets, Congressional leaders are calling for a "devolution" of the Medicaid program to the states in the form of block grants. In exchange for reductions in the growth of federal funding for Medicaid, Congressional leaders are promising the states

relief from federal requirements including those related to eligibility, benefits, and provider reimbursement standards.

The MMA urged the Minnesota lawmakers to preserve the following elements in any restructuring of Medicaid:

- Income-based standards that safeguard Medicaid eligibility for the most vulnerable populations including pregnant women, children, and dual Medicaid-Medicare eligibles.

- Federal funding that takes into account each state's population growth rate and the efficiency of its

Medicaid program.

- Standards that states must meet to ensure that beneficiaries have access to an adequate set of quality health care services. Access standards should include standards for provider reimbursement that will secure adequate provider participation.

- Standards for health plans that participate in Medicaid to ensure that beneficiaries are protected from practices that are unfair or impair the quality of care they receive.

- Requirements for public notice and input regarding state Medicaid policies to ensure that as states assume more control over Medicaid, they are accountable for policies that affect Medicaid beneficiaries and providers.

Medical Assistance Ad Hoc Working Group Is Formed

In addition to these general principles, the MMA is developing specific recommendations regarding the restructuring of Medical Assistance (MA), Minnesota's Medicaid program. The MMA Medical Assistance Ad Hoc Working Group is reviewing the MA program and considering reforms that may be necessary to respond to federal budget cuts. The expected flexibility for states gives the MMA an opportunity to review the entire MA program and make recommendations on how the state can stay within its budgetary limits and still ensure that the critical aspects of the MA program continue. The timeline for the work group is short and intense. The first meeting was held September 7 and the group hopes to complete its final recommendations by the middle of October. Members of the working group include Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees; Carolyn J. McKay, M.D.; Anthony C. Jaspers, M.D.; Charles N. Oberg, M.D.; Nicole Lurie, M.D.; Robert K. Meiches, M.D.; Eugene C. Ott, M.D.; Barbara A. Leone, M.D.; Ronald G. Johnson, M.D.; Nelson D. Sirlin, M.D.; and William Brouwer of the Minnesota Medical Group Management Association. ♦ ♦ ♦ ♦ ♦

Analysis of AMA Medicare Proposal Shows Savings of \$162 Billion

The accounting firm Price Waterhouse has analyzed the American Medical Association proposal to transform Medicare and estimated savings of at least \$162.2 billion over a seven-year period. This would reduce the annual growth in Medicare spending to 7 percent each year. If continued through fiscal year 2002 and beyond, the AMA proposal would keep the Medicare Hospital Insurance Trust Fund solvent for future generations. The AMA plan does not call for massive arbitrary budget cuts, and it does preserve the option of the traditional Medicare program.

Cost Sharing Restructured

Each year only 11.4 percent of Medicare beneficiaries pay out of pocket for their health care because most expenses are paid by Medicare or supplemental Medigap policies. Coverage costs a typical Medicare beneficiary about \$1,544 each year—\$533 for Medicare premiums and about

\$1,011 for a Medigap policy to cover cost sharing. Under the AMA proposal, there would be a more comprehensive package of benefits so Medigap policies would be unnecessary. The only cost sharing would be a single \$500 annual prepaid deductible. Any unused portion of the deductible would be refunded so there would be an incentive to use medical services prudently. Price controls would be eliminated and physicians would determine their own fees. After studying the AMA proposal, Price Waterhouse predicted that about 90 percent of Medicare beneficiaries would pay the same amount or less than they currently pay. Savings to American taxpayers are estimated to be \$44.7 billion over seven years.

Medichoice Introduced

Beneficiaries who choose Medichoice would receive a voucher that would enable them to purchase any type of

insurance they wished from an HMO or PPO to traditional insurance. Beneficiaries would pay the difference if the cost of the plan is more than the government contribution. Beneficiaries could also choose a medical savings account option, which would allow them to buy a high-deductible catastrophic medical plan and deposit the premium savings in their MSA. According to the AMA, Medichoice would save the government money by reducing Medicare's "open-ended entitlement."

Restore Part A Trust Fund to Solvency

In order to fund hospital services, the AMA proposes that the Medicare subsidy be reduced by 20 percent for individuals with incomes greater than \$50,000 and for couples with incomes greater than \$100,000. Funding for graduate medical education should be reduced over time as the private sector takes on a larger funding and planning role. Medicare should no longer reimburse providers for unpaid co-insurance or deductibles.

M E D I C A R E N E W S

ORDER YOUR BILLING MANUAL

Effective January 1, 1996, Minnesota providers are required to use the HCFA 1500, the HCFA 1450 (UB92), or the American Dental Association claim forms to submit bills to payers. The 1994 Minnesota-Care legislation also requires payers to accept these forms for claim payment purposes.

To help you complete the claim forms, the Administrative Uniformity Committee developed the "Standards for Use" manual. This manual provides non-institutional providers with instructions for uniform completion of the HCFA 1500 and the ADA claim forms. Using the guidelines outlined in the manual

will improve consistency in data and help reduce health care administrative costs. The UB92 manual is still available separately to institutional providers who must complete the HCFA 1450 form.

The "Standards for Use" manual is available through the Minnesota Bookstore. You can reserve a copy by calling the bookstore at 612/297-3000. The manual's cost of \$19.95 includes updates.

.....

MEDICARE FRAUD ALERTS

Two national Medicare Fraud Alerts have been issued.

Misrepresentation and inappropriate

billing of orthotic L codes. Some durable medical equipment suppliers are allegedly billing for orthotic L codes when in fact they are delivering heating systems, which are not covered by Medicare.

Inappropriate billing for ultraviolet cabinet. There has been an increase in the submissions for ultraviolet cabinets. Although Medicare is being billed under HCPCS Code E0690 for a very expensive ultraviolet cabinet, beneficiaries are allegedly receiving a very inexpensive table style heat lamp. This item does not require prior authorization or a certificate of medical necessity. It can be very dangerous if not used properly.

MMA Urges Legislators to Reform Professional Liability

What physicians fear most is that they will be sued, not for practicing bad medicine, but for obtaining a bad outcome," Lyle Munneke, M.D., told legislators at a hearing on professional liability reform in Granite Falls September 11. Munneke, a family physician in Willmar, testified on behalf of the Minnesota Medical Association at a hearing before the MinnesotaCare Division of the House Committee on Health and Human Services, chaired by Rep. Roger Cooper, DFL-Bird Island. David Bounk, president of Midwest Medical Insurance Company, addressed insurance issues and was available to answer legislators' insurance questions.

Munneke told legislators that the MMA proposes reforms similar to those that have successfully reduced malpractice premiums in California

—the California Medical Injury Compensation Reform Act (MICRA). These reforms cap non-economic damages for pain and suffering at \$250,000, place a sliding scale cap on attorney contingency fees, and require periodic payments for large settlements.

"The current system benefits the attorneys more than the injured patient," Munneke said. According to a Rand Corp. study, only 43 cents of every dollar spent on medical liability litigation reaches injured patients. The other 57 cents is spent on plaintiff and defense attorney fees, litigation expenses, and insurance administration costs.

Minnesota physicians are more concerned about the negative impact of defensive medicine than they are about malpractice premiums, which have remained relatively stable in

recent years. "When a large malpractice settlement is awarded, it has a chilling effect on any physician who is performing similar procedures," Munneke said. "As a result, the physician takes additional cautionary steps to protect against the slightest risk of being sued." The national cost of defensive medicine was estimated to be \$25 billion in 1991. The Physician Payment Review Commission, which was established by Congress to advise on Medicare issues, stated in its 1994 report to Congress that much of the unpredictability and inconsistency that characterize today's malpractice awards is because of non-economic damages (i.e., pain and suffering), which account for about 50 percent of total payments.

Minnesota trial lawyers also testified before the committee, opposing changes in the professional liability law. Cooper also held hearings on professional liability reform August 28 and October 1 in St. Paul.

• • • • •

Sexual Assault Nurses Ask for MMA Support

• • • • • AS *THE MONITOR* GOES TO press, a resolution is on its way to the MMA House of Delegates that asks the association to endorse the Sexual Assault Resource Service and support its expansion throughout Minnesota.

Since 1977, nurses working for the Sexual Assault Resource Service (SARS) have been providing primary care to rape victims in Minneapolis. In seven hospital emergency departments, specially trained SARS nurses are on call to provide care and counseling to rape victims and to collect evidence that can be used by the prosecution if the case goes to court. In addition, the SARS nurse evaluates the vic-

tim's risk of pregnancy and offers medication to reduce the risk of contracting a sexually transmitted disease. The same nurse who sees the rape victim in the emergency department is also available to prepare the victim for her appearance in court and to provide follow-up counseling for a year.

"Sexual assault nurses provide a valuable service not only to the patient, the emergency nurse, and the physician, but also to the police and county attorney," said Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees and author of the resolution.

The nurses' specialization in sexual assault offers many advantages.

A SARS nurse may perform three evidentiary examinations in one day while some ER staff may do only one such exam in six months. Experience in this type of exam prepares nurses to preserve evidence that can put a rapist behind bars. A SARS nurse also testifies in court as one of the responsibilities of her job. This means that emergency department nurses and physicians do not have to take time away from treating patients to testify.

First introduced at the Hennepin County Medical Center in Minneapolis, SARS was developed by Linda E. Ledray, R.N., Ph.D., in 1977 and is now used by six other private hospitals in Minneapolis. Currently, SARS is planning to expand its services to eight regions throughout Minnesota.

STOP THE VIOLENCE

MMA ALLIANCE PLANS FOR SAVE TODAY

The Minnesota Medical Association Alliance, a volunteer organization of physicians' spouses, is participating in the American Medical Association Alliance's nationwide anti-violence initiative, "SAVE: Stop America's Violence Everywhere." The centerpiece of the year-round program is SAVE Today, an event on October 11, 1995. The Alliance plans a full week of activities October 9 to 13 in Rochester beginning with a Peace Rally on October 9 and including a symposium on violence October 13. For more information about Rochester activities, call Mary Lanier, 507/288-2367.

CELEBRATE TURN OFF THE VIOLENCE DAY OCTOBER 12

Violence is a learned behavior. It can be unlearned. This belief is at the heart of Turn Off the Violence, a grassroots coalition of organizations including the Minnesota Medical Association, which is working to reduce violence.

On October 12, the coalition is celebrating Turn Off the Violence Day. On this day, the coalition urges every Minnesotan to take these steps:

- Turn off violent television programs. Don't listen to violent music. Don't go to violent movies or rent violent videos.
- Voice your opinions to television and radio stations about their programming.
- Be aware of the ways you resolve conflicts and choose positive non-violent solutions.
- Arrange to have information about the Turn Off the Violence campaign included in your school, office, or religious newsletter.
- Ask your school district, principal, or your child's teacher to include

creative conflict resolution concepts in their lesson plans.

The coalition, which is administered by the Citizens Council, offers a 40-page booklet filled with ideas for teaching conflict resolution to children preschool age through grade 12 as well as a community action planning kit. For more information, contact Turn Off the Violence, PO Box 27558, Minneapolis, MN 55427. Or call 612/593-8041.

'DAY OF LEARNING' ANTI-VIOLENCE FORUM

"The Day of Learning," an anti-violence forum, will be presented October 27 to 28 at Ruttger's Resort in Brainerd. The forum includes the premiere of a musical play, "Violence—What Can One Person Do?" as well as a violence prevention expo, small and large group discussions of the dynamics of violence, and examples of what community groups are doing to make a difference. It will end with communities making commitments for three action steps to create violence-free communities. A diverse group representing human services, health care, media, law enforcement, the religious community, and grassroots leaders are expected to attend. For more information, call Shirley Pierce at 612/266-8020 or Frank Jewell at 218/726-2067.

'VIOLENCE. WHAT CAN A PERSON DO?'

The musical, "Violence. What Can a Person Do?" by Dick Wilson and DeAnn Allison explores the pain, anger, fear, and resentment inherent in violence and comes to a hopeful resolution. The musical, presented by Stradivarius Productions in collaboration with Hamline University and Hennepin Avenue United Methodist Church, will be per-

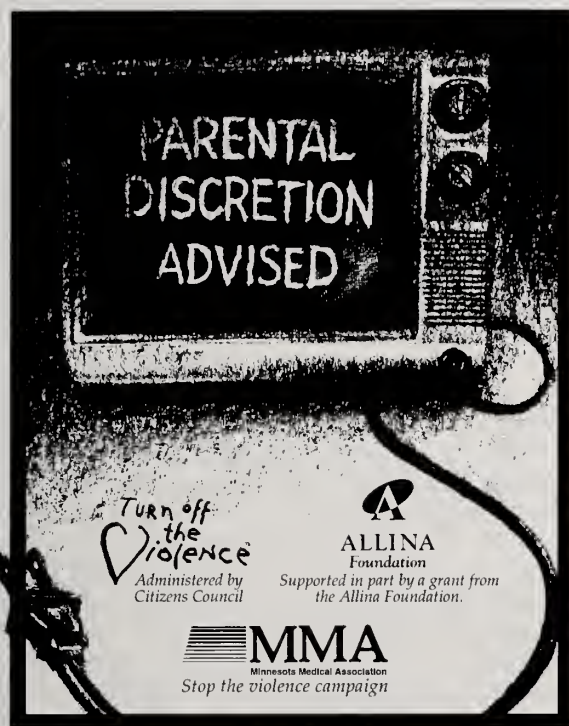
formed at the Anne Simley Theatre in St. Paul. Remaining productions are October 5 to 8. Tickets are \$15. For more information or to order by phone, contact the Office of Church Relations at 612/641-2032.

HELPING TEENS STOP VIOLENCE

The seminar, "Helping Teens Stop Violence," will be presented by Paul Kivel October 30 and 31 at the Ramada Inn in Minnetonka. Based on the work of the Oakland Men's Project and the book *Helping Teens Stop Violence* by Kivel, the seminar will use role play, interactive exercises, and group discussion to examine male and female socialization, the social roots of teen violence, and economic, racial, and gender issues in teen relationships. Exercises and techniques for working with young people in one-on-one and group situations will be demonstrated. Registration begins at 8 a.m. on Thursday, October 30. Sessions begin at 8:30 a.m. and adjourn at 3:30 p.m. each day. The conference fee of \$155 includes lunch and breaks. For registration information, call 612/424-0880.

FREE VIOLENCE PREVENTION VIDEOTAPE IS AVAILABLE

The Offices of Special Education and Prevention and Risk Reduction of the Minnesota Department of Education have developed a 15-minute violence prevention videotape, "Back to Love." The videotape, aimed at parents and caregivers, conveys the message that help is available and that it can make a difference. The tape shows people who have experienced domestic violence and encourages others to seek help. To obtain the videotape at no cost, call Pam Jones, Minnesota Department of Education, 612/282-5086.



Stop the media violence

Media violence is a health hazard to kids. As a physician, you can help by educating patients! Provide parents with information on taking charge of the media in their children's lives by limiting viewing, providing choices, and talking about what is being shown.

For further information, or to order posters and brochures to display in your office, contact:

Minnesota Medical Association
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
612-378-1875

ANNOUNCEMENTS

HTAC SOLICITS COMMENTS ON NEUROIMAGING REPORT

The Health Technology Advisory Committee (HTAC) of the Minnesota Health Care Commission has completed its preliminary report on the evaluation of neuroimaging to diagnose headache. The August 14 *State Register* includes a brief summary of the report's conclusions and a request for written comments. A copy of the report may be obtained by contacting Kris Iverson at 612/282-6331. If you have questions about the technology evaluation process, call Mary Fahey at 612/282-6355. Public testimony on the HTAC's evaluation of neuroimaging will be accepted by the Minnesota Health Care Commission on October 18.

DR. VAN GORP REPRESENTS MMA ON X-RAY GROUP

Paul Van Gorp, M.D., has been

named the MMA representative on the Minnesota Department of Health advisory group on the examination for x-ray operators. Legislation adopted in 1995 calls for the creation of a work group to make recommendations regarding the examination that will be required for x-ray operators after January 1, 1997. The examination must be designed to demonstrate the individual's knowledge of basic radiation safety, proper use of x-ray equipment, darkroom and film processing, and quality assurance procedures. The MDH expects to adopt revised rules by April 1996.

The MDH has requested comments on the subject matter of the rules. Written statements should be addressed to Judith Ball, manager, radiation control, MDH, Division of Environmental Health, 121 Seventh Place, Suite 220, St. Paul, MN 55164-0975. Her phone number is 612/215-0945. A copy of any draft

proposals under consideration may be obtained from Ball.

REPUBLICANS WILL HOLD HEARINGS ON HEALTH PROGRAMS

Members of the Republican Caucus of the Minnesota House of Representatives have formed a task force to study publicly funded health care in Minnesota. Members of the task force will co-chair public hearings throughout Minnesota and will use the information gathered at these meetings to draft legislation for the 1996 legislative session. The schedule of the remaining task force hearings is as follows: Rochester, October 17; Wadena, October 19; and Faribault, October 26. Additional hearings may be scheduled. For information about times and locations, contact the office of Rep. Fran Bradley, R-Rochester, the chair of the task force, at 612/296-9249.

Beware of Silent PPOs: Does Your PPO Contract Allow Them?

The American Medical Association warns of a widespread practice that is silently eroding physicians' incomes. Discounts that providers have agreed to in their preferred provider organization contracts are being sold and applied to patients who are not in the PPO. When physicians challenge this practice, they may get their money back, but too often they do not catch the discrepancy. As a result, they lose a substantial amount of money in inappropriate or illegal discounts.

Unless a contract specifically allows them, these so-called "silent" PPO transactions are illegal in Minnesota, thanks to a provision that the Minnesota Medical Association succeeded in inserting into last year's MinnesotaCare legislation. But Minnesota physicians should be aware of whether or not their contract allows the practice of selling or renting discounts. This clause may be overlooked.

MinnesotaCare Law

According to the 1995 MinnesotaCare law, an insurer cannot claim the right to a discounted fee unless the insurer has a discount agreement with the provider for the patient involved, or unless the physician has signed an agreement expressly allowing an entity to assign its right to receive the discount. In this case, the explanation of benefits must prominently state that the discount is based upon assignment and must reveal the name of the entity from whom the assignment was received. No insurer that has entered an agreement with a provider that involves discounted fees may disclose the discounts to another entity if the insurer knows that such disclosure will result in claims for discounts that are prohibited by this law.

Unscrupulous Brokers

There is also a danger that unscrupulous brokers may buy and sell dis-

counts despite the law. According to *AM News*, a federal grand jury in Wisconsin indicted an employee of a California firm for allegedly gouging \$100,000 in improper discounts from physicians and hospitals in Wisconsin. The AMA reports that the FBI is looking into such fraudulent practices throughout the country.

Tips on Avoiding Improper Discounts

The AMA suggests the following steps to protect your practice from improper discounts:

- Be sure a PPO contract requires all payers to offer participants significant financial incentives to encourage the use of network providers or penalties for the use of non-network providers.

- Avoid PPOs that do not prohibit their payer clients from using many different PPOs in the same geographical area. If an employer or payer can obtain discounts from all the providers in a given location by signing many PPO contracts, all the providers receive lower fees even though none receive "preferred" status.

- Require all PPO participants to show their insurance card with their PPO membership.

- Do not allow the PPO to extend your discounts to anyone other than a payer of health claims. Some PPOs sell access to their discounts to intermediaries such as brokers or utilization review companies.

- Keep a list of all PPOs in which you participate.

- Make sure the discount matches the rate agreed upon in the contract.

If you have questions about this issue, call Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875.

Hmong Perspectives on Critical Care

The Minnesota Center for Health Care Ethics is sponsoring its first diversity summit, Hmong Perspectives on Critical Care, October 27 to 28 at the Crown Sterling Suites Hotel in Bloomington.

The Hmong community is conducting this conference for Western health care professionals who are interested in Hmong perspectives on critical illness and critical care. Conference speakers include Hmong health care professionals, religious and community leaders, traditional healers, patients, and family members. The speakers will describe case studies and will share their community's cultural beliefs, faith perspectives, and practices regarding critical care decision making. There will also be an opportunity for audience questions and discussion.

For more information or for registration materials, please call Margie Noonan at the Minnesota Center for Health Care Ethics at 612/690-7895, or fax information to her at 612/690-7774.

The Monitor

OCTOBER 1995

...

PRESIDENT

Michael J. Murray, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

...

**An auto lease/purchase
company solely dedicated
to serving physicians.**

MMBR MOTOR SERVICES



**Here's what
MMBR MOTOR SERVICES
is committed to doing
for you:**

When you call us, we go to work providing free consultation to help you outline your vehicle needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle. Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease we will arrange to have your vehicle professionally detailed, assuring high resale value by helping keep your vehicle in top condition.

We provide complete support after the lease/purchase. If you have a question, call us.

For *personal attention* on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 1/800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.



MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

WEBB FINANCIAL GROUP

INVESTMENT ADVISORS

FOR INVESTORS WHO ARE LOOKING
FOR A FEE-BASED RELATIONSHIP,
THE QUESTION IS STILL THE SAME

No Load?

WEBB FINANCIAL IS THE ANSWER.

No Problem.

With over \$60,000,000 in assets under management, Webb Financial is recognized as a leader in the construction and management of NO-LOAD (zero commission) mutual fund portfolios for individuals, and retirement plans across America.

We believe our mutual fund research and model portfolios
— free from any proprietary influence —
set the industry standard for fee-based programs.

Our model portfolios cover an entire spectrum of investment objectives.

Our mission is to help you and your clients reach investment and income objectives with safety. Call a personal investment advisor at Webb Financial Group for a no-cost, no-obligation consultation

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

Freedom of Choice in Health Care Today

Myth or Reality?

During a preceptorship program, this medical student found that patients have limited choices concerning their health care, but they are, nonetheless, satisfied customers.

Monica Wietgreffe

Health care reform is bringing many changes to the delivery of health care services in Minnesota. As part of a preceptorship program, I recently observed the delivery of rheumatology care in four distinct settings in the Twin Cities area: traditional fee-for-service, single-payer government-run, a large HMO, and a clinic hybrid of fee-for-service and managed care. What I observed concerning access, prescriptions, and referrals for surgery suggest that patient choice is limited for many reasons, but patients are, nonetheless, quite satisfied with their care.

Access

Expanding access to health care is a cornerstone of most health system reform bills. In the rheumatology offices I observed, access was determined by the primary care providers, who acted as gatekeepers; they provided basic rheumatology care and requested referrals for patients with rheumatology problems beyond their capabilities and training.

The universal feeling among the rheumatologists in all these settings was that many patients had been inadequately managed before being referred to a rheumatologist, suggesting that not all primary care physicians are making appropriate or timely referrals in their patients' best interests. In three of the four clinics I visited, at least one patient with rheumatoid arthritis was treated with aspirin or NSAIDS for prolonged periods, despite minimal improvement.

In each case, the consulting rheumatologist said methotrexate would have been indicated earlier in the course of the disease. The rheumatologists attributed this common delay, in part, to some primary care physicians' reluctance to refer, their insufficient training in diagnosis and treatment of such disorders, and their inability to recognize their own limitations. Such impressions prompted the rheumatologists to follow many of the patients referred to them, rather than return the patients' rheumatology care to the primary physicians.

Rheumatologists are trained in general internal medicine and are, therefore, qualified to provide such care to their patients. However, the level of care the rheumatologists provided varied. The rheumatologist in the large HMO preferred not to manage non-rheumatologic problems. The rheumatologist in the fee-for-service practice also chose not to provide general medical care, but said that to maintain a viable practice in today's health care environment, she may need to change her approach. At the Veterans Affairs Medical Center, the rheumatologists served as primary providers for patients with complicated systemic rheumatic diseases. The hybrid clinic provider also delivered primary care to some patients.

Patients' access to rheumatologists was limited to some extent within each of these delivery systems. Under managed care and government systems, the patient was re-

ferred to a rheumatologist within the same system; choice of rheumatologist was constrained by the system. Within the hybrid, patients were referred from within as well as outside, but like the traditional fee-for-service practice, the patients often were allowed to choose only providers whose services were covered by their insurance programs. Interestingly, proposed health system reform plans are often criticized for limiting patients' freedom to choose their physicians. Apparently, however, most patients already have limited choice.

In all four settings, patients abused the system by not showing up for appointments and not calling to cancel. Other patients could have used the appointment time wasted by the no-show patients.

In the three multispecialty practice settings, other specialists were readily available to the rheumatologists, and the rheumatologists were available to other physicians seeing patients in the same clinic area. For example, one woman who had severe arthritis and nonhealing pressure sores was seen immediately by the dermatologist. Several times, a generalist physician obtained a quick rheumatologic consult on patients with possible gout. Most patients seemed to appreciate this convenience and efficiency.

Prescriptions

I was surprised to find that availability of medications was limited in each health care setting, although the

extent of limitations and the mechanisms available to bypass them varied. The physicians were constrained by drug formularies—frequently developed without input from the prescribing physicians. In the HMO and VAMC clinics, obtaining approval for a non-formulary drug, after trying the formulary medications first, was fairly straightforward. At the hybrid and fee-for-service office practices, selecting a medication was much more complicated because all the insurance plans had their own formularies. These formularies were frequently amended, and the rheumatologists were challenged to keep current about which plans allow or disallow which medications.

The type of health care system also influenced patients' abilities to fill prescriptions. The government-run setting offered the surest system; patients received their medications at no cost or for a \$2 copayment. Within the other systems, copayments varied depending on the patients' insurance plans; some managed care patients had a minimal copayment, some had a larger copayment, and

others had to pay the full cost of each medication. Patients who had no insurance or those who had to pay the full cost of the drug benefited when the rheumatologists considered drug costs and knew about links to social services, mail-order pharmacies, and drug companies' indigent patient programs. Nonetheless, affordability of medication was a major issue, especially for patients who were taking multiple medications. Again, neither patients nor their physicians had complete freedom to choose treatments.

Surgery Referrals

I also compared referral for joint replacement surgery. As might be expected, the fee-for-service setting provided greater options for both patient and physician, although very real limitations were imposed by patients' insurance plans. One elderly man needed a total hip replacement but could not afford the 20 percent copay. Patients frequently relied on the rheumatologist's recommendation of surgeon, and within the fee-for-service system, physicians had the latitude to choose the surgeon with

the greatest expertise in performing the specific joint replacement needed. The HMO care system had no surgeons on staff, but subcontracted with a number of surgical practice groups for services, which limited choices for patients and physicians. Problems with continuity of care can occur if the HMO management changes contracts during the course of a patient's treatment. In spite of these limitations, however, the HMO rheumatologist felt she could intervene if a problem developed between the patient and surgeon. At the VAMC, choice of surgeon was primarily restricted to surgeons on staff.

Conclusion

My observations revealed a recurrent theme: neither patients nor physicians are afforded complete freedom of choice in health care. The four delivery systems I observed demonstrated a continuum of limitations, resulting from the administrative decisions made by the management of the parent organizations regarding which drugs to include in formularies and which physicians to include in their systems. In many (but not all) cases, patients had chosen their health care insurance plans, but it's unlikely they had full knowledge of the programs' limitations. Perhaps surprisingly, patients whose financial circumstances offered them little or no choice in health insurance options (for example, VAMC patients) faced no greater limitations than patients in other systems. Because I observed many fully satisfied patients in all four health systems, I believe the oft-cited concern that health system reform provisions will provide unacceptable limitations on choice is a moot issue. MM

Monica Wietgreffe is a third-year medical student at the University of Minnesota. In the summer of 1994, she was selected to participate in the American College of Rheumatology Clinical Preceptorship Program for medical students. Her preceptorship was directed by Maren L. Mahowald, M.D., rheumatology section chief at the Minneapolis VAMC and professor of medicine at the University of Minnesota.

North Central Medical Conference Presents

CHINA - YANGTZE RIVER CRUISE - HONG KONG

March 20-April 4, 1996 (16 days) \$2,999.00 (Plus Taxes)

March 14-26, 1996 (12 days) \$2,559.00 (Plus Taxes)
per person, double occupancy

The resplendent grandeur of China's ancient dynasties beckons you across 3,000 years of history, art, and struggle for perfection. Cruise the Yangtze River through the most spectacular stretch of river scenery. Visit Hong Kong, one of the most exciting places on earth.



BEST OF THE ORIENT

March 17-27, 1996 (11 days)

\$2,349.00 (Plus Taxes)

per person, double occupancy

In Bangkok discover the treasures of the Kingdom, a land of unsurpassed scenic beauty. Singapore, the most surprising island on earth, a multi-cultural Mecca with Chinese, Malay, and Indian influences, and cosmopolitan, energetic Hong Kong.

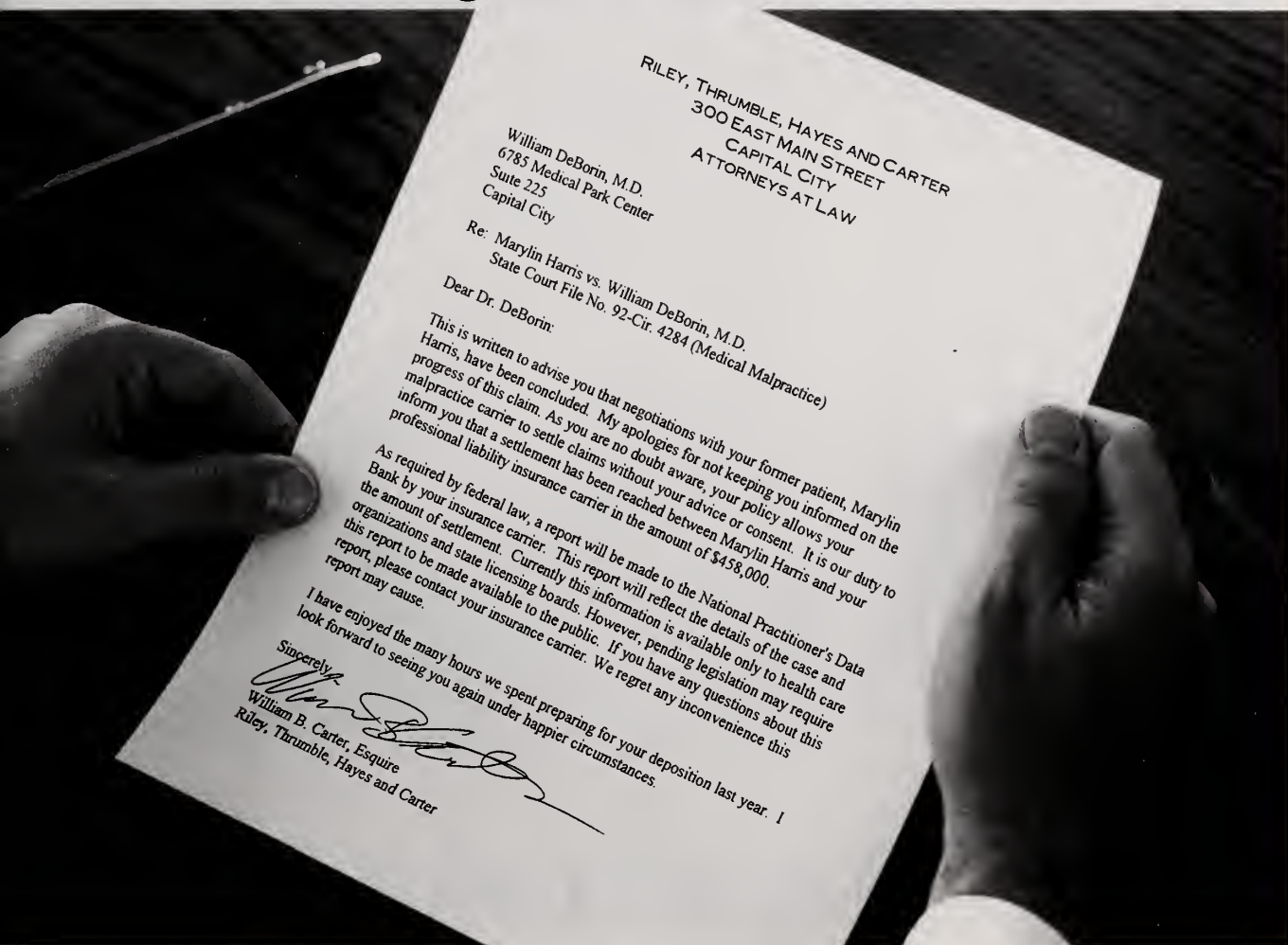
AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.

For additional information and a color brochure contact:

GLOBAL HOLIDAYS

9725 Garfield Avenue South, Minneapolis, MN 55420-4240 (612) 948-8322 Toll Free: 1-800-842-9023

Medical Protective Policyowners **NEVER** get letters like this!



RILEY, THRUMBLE, HAYES AND CARTER
300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marilyn Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

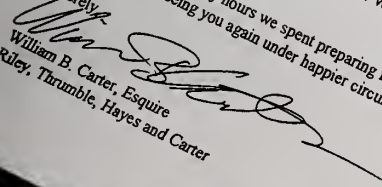
Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marilyn Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marilyn Harris and your professional liability insurance carrier in the amount of \$458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,


William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

800/344-1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's



TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 270 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice
- Psychiatry
- Psychology
- Orthopaedics -
- Child/Adolescent
- Detroit Lakes,
- Urgent Care
- Bemidji
- ENT - Bemidji



For more information contact:
Kathleen McKittrick Toft,
 Director, Physician Recruitment
1-800-437-4010



FAMILY PRACTICE OPPORTUNITIES

HealthPartners

HealthPartners offers excellent family practice opportunities for BC/BE family practitioners. HealthPartners, a staff-model HMO, offers its physicians excellent salaries, generous benefits, a balanced lifestyle with practice scheduling flexibility, and the opportunity to practice medicine without the headaches of managing an office.

The Family Practice Department is staffed by over 75 BC/BE physicians and offers a broad range of full-range and limited-range practice options.

To inquire about specific opportunities, please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Avenue South, PO Box 1309, Minneapolis, MN 55440-1309.



HealthPartners

HealthPartner's mission is to improve the health of our members and our community.

Data Privacy Under MinnesotaCare

The 1995 Legislature created a complex scheme for protecting the privacy of data collected under MinnesotaCare.

Mary Prentnieks, J.D., and Shirley Qual, J.D.

When the state Legislature scaled back MinnesotaCare last session it also rewrote critical portions of the data collection laws. As a result of the 1995 revisions, the state continues to embark on an ambitious data collection campaign with the ultimate goals of improving quality of care and reducing health care costs. The state will be collecting, analyzing, and disseminating patient health care data generated by providers, group purchasers, employers, and integrated service networks. Obviously, this raises data privacy concerns for both patients and those generating the data. Patients will be concerned that their confidentiality may be compromised. Providers and entities who are the subjects of the data will want to ensure that information released is accurate, useful, and valid.

This article discusses how the most recent revisions to MinnesotaCare clarify the roles of those responsible for the state data initiatives and describes how the 1995 Legislature changed the law to address privacy concerns and better protect patients, providers, and others from the inappropriate disclosure of data.

Roles and Responsibilities

The primary responsibility for the collection, analysis, and dissemination of data lies with the Minnesota Department of Health, a state agency, and the Minnesota Health Data Institute, a partnership between the public (Department of Health) and

the private sector. The Data Institute is composed of a board of directors representing group purchasers, health care providers, consumers, and representatives from certain state agencies. (For more on the Data Institute's activities, see sidebar, page 48.)

The 1995 legislative revisions to MinnesotaCare clarify the Department of Health's and the Data Institute's roles. In general, the legislation gives the Department of Health responsibility for population-focused and traditional health department data initiatives. Data initiatives pertaining to performance measurements in the marketplace are now clearly the responsibility of the Data Institute.* While the Department of Health continues to have broad authority to collect data, the Data Institute must rely on voluntary submission of data by industry participants and information shared by the Department of Health.

Whether the data are collected, maintained, and disseminated by the Data Institute or the Department of Health will have an important bearing on the privacy protection of the data, because the 1995 Legislature enacted separate data privacy protection provisions for each organization. In addition, data maintained on

the Data Institute's electronic data interchange (EDI) system (see sidebar, page 48, and related article, page 52) are exempt from these data privacy protections and are subject to current data privacy laws. The following discussion describes the complex scheme developed by the Legislature to protect data privacy.

Classification of Patient- & Nonpatient-Identifiable Data

One important goal of MinnesotaCare's new data initiatives is to protect patient- and nonpatient-identifiable data as private (available to the subject of the data only) until the requirements necessary to release the data, as determined by the Department of Health or the Data Institute, have been met. Under the law, patient-identifiable data will remain private. Data identifying providers, group purchasers, and integrated service networks (nonpatient data) may be released in certain circumstances.

Prior to the 1995 legislative changes, the law called for assigning all patients their own health identification number by encrypting (scrambling) patient Social Security numbers (or an alternative number in certain circumstances) to ensure the protection of patient privacy. The Legislature again stressed in the 1995 revisions of the law that encryption must make it impossible to identify individual patients. The new version of the law also requires providers, group purchasers, and health plan

*The Minnesota Department of Health may perform the functions of the Data Institute only if the department determines that the Data Institute will not be performing those functions.

companies to use an encryption method when patient data are submitted electronically to the Department of Health or the Data Institute.

The Legislature also added new protections for patient- and non-patient-identifiable data maintained by both the Department of Health and the Data Institute. Without these new protections, the classification of private data could have changed to public when, for example, the data

were transferred to the state archives or after an individual died.

One clarification added to the law should assure providers, group purchasers, and health plan companies that they no longer have to fear a lawsuit by a disgruntled patient over the release of confidential patient data as required by MinnesotaCare. In the past, the law was unclear whether patient consent was required to release patient information for the

purposes of MinnesotaCare data collection initiatives. In addition, the law afforded no immunity protection. The lack of clarity and immunity for providing patient data raised concerns for providers. As a result of lobbying by the Minnesota Medical Association, the law now addresses this issue with explicit language authorizing providers, group purchasers, and health plan companies to release data as required to the De-

The Minnesota Health Data Institute

Health Information Infrastructure

The Minnesota Health Data Institute is developing and implementing a statewide health information telecommunications infrastructure to support the long-term information needs of health care system participants. MedNet and the Minnesota Center for Healthcare EDI are two key components of this endeavor.

MedNet is a statewide, nonproprietary, electronic health care information network utility developed for the external communications of clinical, administrative, and analytical information to support and improve health care delivery and financing operations throughout Minnesota. MedNet is being implemented in three phases. Phase one, begun in August to a limited extent, electronically links a set of core health care organizations for the transmission of administrative data. The Data Institute hopes to expand services and to have phase one completely functional by the end of the year. During phase two, linkages will be expanded to include smaller clinics outside the metro area, and clinical data may be transmitted on the system. During phase three, the final stage, statewide linkages and full-service access will be completed.

The Minnesota Center for Healthcare EDI is an educational training program designed to advance the use of electronic data interchange in Minnesota's health care industry. The center is set up to conduct a series of training courses, house an EDI resource center, and develop a common implementation guide based on national EDI standards. Training courses have already begun and are scheduled monthly. Minnesota's implementation guide for the electronic transmission of health care claims is currently being completed. Providers who exchange documents electronically will be required by law to submit or accept data in the standard format prescribed by ASCX12 (American Standards Committee X12, see related article, page 52) effective six

months after the commissioner of health approves Minnesota's implementation guide, which complies with the national standard. Use of the state's implementation guide is recommended, but not required, for meeting the national standard. The Minnesota Data Institute expects that the Minnesota commissioner of health will approve the guide in January 1996.

Performance Measurement and Improvement

The Data Institute is working collaboratively with all major stakeholder groups to design and implement standard methods for comparing the quality and cost of care provided by competing health plans and provider systems. Two projects currently underway are a 1995 consumer survey and a health plan information demonstration project.

The statewide consumer survey compares consumer satisfaction and perceptions of performance across 46 different health plans, including public and private managed care and fee-for-service programs. The results will be distributed this month to coincide with open enrollment for choosing a health plan.

The health plan performance information demonstration project will evaluate the usefulness of providing health plan performance information to consumers. This project is scheduled for completion by early 1997 and will provide information to all participating organizations regarding content and methods for designing and disseminating comparative health plan performance reports for consumers.

Data Privacy and Disclosure Policy

The Data Institute also is developing policies and procedures to protect the confidentiality of person-identifiable data and to assure fairness to all groups affected by access to and disclosure of data the institute collects.

partment of Health and the Data Institute without patient consent. It also extends immunity from civil liability and criminal prosecution for the release of data in good faith.

Privacy Protection of Data

DEPARTMENT OF HEALTH DATA

Data collected by the Department of Health to fulfill the data and research initiatives of MinnesotaCare are classified as private. However, the Department of Health may publish data at its discretion on health care institutions, individual health care professionals, and groups of health care professionals, group purchasers, and integrated service networks after providing interested parties 21 days to review the data and make comments. The Department of Health must include these comments with the data when they are released. The provision serves two main purposes: 1) it prevents release of the data before they have been appropriately synthesized for dissemination, and 2) it gives the subjects of the data an opportunity to clarify, comment, or lodge objections to the form or analysis of the data.

In addition, the Minnesota Medical Association worked with the Department of Health to prompt changes to the law that allow a provider or group purchaser to contest whether the data are based on scientifically sound and statistically valid methods. To obtain a contested case hearing, the provider or group purchaser must make a written request to the Department of Health during the period for review and comment. The provider or group purchaser must demonstrate to an administrative law judge the likely success in a hearing on the issue of whether the data are accurate and valid and were collected based on scientifically sound and statistically valid methods. If the administrative law judge determines that the provider or group purchaser has failed to make such a showing, the Department of Health may publish the data immediately so long as comments received from the objecting party are included with the data.

The contested case proceeding was a compromise measure allowing

timely release of the data while simultaneously ensuring that only useful and accurate data are disclosed. The law is still untested, and it is unclear how helpful it will be for providers and group purchasers contesting the inappropriate release of their data. Nevertheless, the legislation provides an administrative remedy that was lacking in the past.

DATA INSTITUTE DATA

Although the Legislature always intended for the MinnesotaCare data collection initiatives to provide privacy protection for the subjects of the data, prior to the changes enacted in the 1995 session, the law failed to fully protect data maintained by the Data Institute on patients and providers. The 1995 Legislature corrected this problem by adding key language to the law that explicitly protects both patient and provider data as private, although, as with data maintained by the Department of Health, provider-identifiable data may eventually be released. The name of an industry participant (group purchaser, employer with an employee health benefit plan, provider, or state agency or political subdivision) may become public, but only after the Data Institute determines, according to its own criteria, that the data and analysis are sufficiently accurate, complete, reliable, and valid; appropriately case mixed and severity adjusted; and statistically and clinically significant. The MMA vigorously advocated the inclusion of these criteria, which, again, are intended to ensure that only useful data are released, rather than data that could mislead and confuse the public.

The 1995 legislation also requires use of a fair hearing process for industry participants to object to or seek modification of an analysis that the Data Institute plans to disclose publicly. The legislation requires the hearing procedures developed by the Data Institute to include the following provisions: 1) reasonable notice of the Data Institute's intention to make an analysis public; 2) an opportunity to submit written statements to the Data Institute; 3) an opportunity to be represented by someone appointed by the industry

participant; 4) an opportunity to append a statement to the analysis when and if the analysis is made public; and 5) access by the industry participant to its own data. The Data Institute must make the hearing procedure available before the data are released. The cost of the hearing will be borne by the industry participant requesting the hearing.

The fair hearing process differs from the contested case proceeding involving data maintained by the Department of Health. Most notably, the development of much of the hearing process is under the discretion of the Data Institute rather than specifically outlined in law.

ELECTRONIC DATA INTERCHANGE SYSTEM

One of the more critical aspects of the legislation enacted during the 1995 legislative session pertains to the privacy protection provision for the electronic data interchange (EDI) system, MedNet. As with any law pertaining to an electronic data interchange system, this provision has far-reaching data privacy ramifications. MedNet, operated by the Data Institute, may be used by the public and private sectors to exchange health care data. The system will electronically transmit, collect, archive, and provide users with the data necessary for their specific interests. The system is designed to promote a high-quality, cost-effective, consumer-responsive health care system.

The privacy protection measures set forth in the legislation that pertain to the Data Institute in general do not apply to the EDI system when data are transferred from one industry participant to another. Instead, data transferred electronically via the EDI system are subject to patient privacy protections already existing in law (including the Minnesota Government Data Practices Act with respect to state agencies and political subdivisions, the Minnesota Insurance Fair Information Reporting Act, and the Minnesota Access to Medical Records Act).

It is unclear from the legislation how provider and other industry participant data will be protected on the EDI system when one industry

participant is transmitting data to another. This area of the law is still evolving, and future revisions are needed to address this issue. The adoption of accepted national standards regarding the electronic transmission of and access to data may

provide an additional safeguard. Future revisions to the law may also be needed to immediately suspend users' access if they are being investigated for possibly breaching confidentiality or inappropriately obtaining access to data. In the meantime,

protection may be placed in contracts between the Data Institute and industry participants.

Release of Data to Researchers

The law allows researchers to access data from the Data Institute that identify industry participants, provided that certain criteria set forth in the law are met. Patient-identifiable data arguably should not be released to researchers, although an ambiguity exists in the law on this point. One provision of the law allows the release of patient-identifiable data to researchers, but it is inconsistent with other provisions found in the law. It is hoped that a future technical change in the law will clear up this ambiguity.

Release of Data to Industry Participants

The new law allows employers or employer purchasing groups access to data maintained by the Data Institute relating to care provided to patients for which that employer acts as payer. Health plans may access data relating to care provided to their enrollees, and providers may access data relating to their patients. Patient-identifiable data may not be released in these circumstances. The legislation also authorizes an industry participant to receive data from the Data Institute that identifies it or other industry participants, provided that authorization from all identified industry participants is first obtained.

Protection Against Discovery

The new legislation prohibits discovery in any civil or criminal action of data that are created, collected, received, maintained, or disseminated by the Data Institute. Discovery of information related to the submission of the data is also prohibited. This safeguard ensures that the nature and subject matter of data requested by the Data Institute are not disclosed during litigation.

Civil Remedies and Penalties

Violation of the confidentiality requirements by the Data Institute, its

HealthEast Capitol Medical Laboratory offers solutions

Providing services to physician office laboratories, long term care facilities, home care agencies, group homes, and corporate health and wellness programs • Professionally staffed • Locally owned and operated • Open 24 hours, 7 days/week • Member HealthEast Community Based Services

Providing solutions and expanded services for your office. For more information, contact CMLMarketing at (612)

232-3246

HealthEast  Capitol

Medical Laboratory

69 West Exchange Street

St. Paul, MN 55102

Customer Service: (612) 232-3500

• Minnesotans serving Minnesotans •

board members, employees and contractors, any industry participant, or any other person may subject the violator to a lawsuit and punitive damages asserted by the injured party. In addition, immunity protections will be lost.

Willful violation of the confidentiality requirements set forth in the law for the Data Institute is a misdemeanor. Additionally, willful disclosure by any person of data that would identify a patient or industry participant for compensation or remuneration of any kind or for the purpose of damaging the reputation of any patient or industry participant or any other malicious purpose is a gross misdemeanor. The imposition of these criminal sanctions raises the stakes for mishandling data. Its impact remains to be seen.

Conclusion

The Legislature made significant strides in attempting to protect data privacy while maintaining the course set by MinnesotaCare for data initiatives. The rapid technical advances and their application in this area will challenge endeavors to maintain data privacy. As the data collection systems develop and evolve, the data privacy laws will warrant continual review to ensure that the privacy protections remain intact. **MM**

This article is a general discussion of legal issues; it is not intended as legal advice and should not be construed as such. If you have specific questions regarding data privacy, contact a qualified attorney.

Mary Prentnieks is former director of legal affairs for the Minnesota Medical Association. She is now working on her master's degree in public health administration at Harvard University School of Public Health. Shirley Qual is a nurse attorney practicing health care law with the law firm of Popham Haik. She and Mary Prentnieks sat on the Data Privacy and Disclosure Task Force of the Ethics and Confidentiality Committee of the Data Institute prior to the 1995 legislative session.

Creative solutions for all your health law problems



Leonard, Street and Deinar
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree[®]

Minneapolis 667-0705

©1995 Norwest Bank Minnesota N.A.
Member FDIC

One for the Money: The Financial Benefits of EDI

Electronic data interchange speeds the flow of data between organizations, reduces data entry errors, and ultimately saves money. This article, the first of three parts, tells how.

Sue Chapin-Strike

Back in 1988, I interviewed for a position with the Health Care Group of 3M to support its electronic data interchange (EDI) initiative. I was very candid in the interview, admitting that I didn't know what EDI was, but assuring that if it was related to computers, I could learn it. I got the job and set off to discover just what I had gotten myself into.

This "new" concept called EDI, the computer-to-computer exchange of data in a *standard* format, was developed by the federal Transportation Data Coordinating Committee (TDCC) in the early 1970s. TDCC recognized that simply replacing a myriad of different forms that performed the same function with a myriad of different computer formats increased speed, but did little to simplify the process. As a result, TDCC published its first set of national standards defining the syntax and structure of EDI in 1975.

Since TDCC was recognized as the leader in EDI, it only made sense to attend its national conference as my first step in the discovery process. The keynote session left an indelible mark in my mind. The speaker walked down the aisle, tossing hundreds of dollars into the air for attendees to grab. After the mad scramble subsided, he calmly announced, "Money, that's what EDI is all about!" He was right—partially. EDI is about saving money, but that's not its only benefit. EDI speeds the flow of data, reduces data entry errors (no re-keying of data is necessary), and eliminates much of the ambiguity of non-standardized data exchange.

Over the past 20 years, TDCC has been replaced by the American Standards Committee X12 (ASC X12), a committee of the American National Standards Institute (ANSI), as the standards-setting organization. The concept of EDI has been accepted, not only by the transportation industry, but by thousands of organizations in hundreds of industries, such as grocery, automotive, electronics, education, legal, financial, real estate, and health care. In health care, business application data (such as data relating to eligibility, claims, adjudication, and payments) in one computer are converted into this standard medium of exchange. The data can be commu-

nicated from one organization, such as a provider, to a trading partner, such as a payer, electronically. Unlike many existing electronic claims systems, EDI requires adherence to a *single standard format* rather than a specific format for Payer A and a different format for Payer B. There is no need to generate paper copies from a computer at one site, or to mail or fax them to another site, where the data is re-keyed into another computer system. Think about the implications! The cost of paper has increased about 40 percent in the last year, the cost of postage has increased approximately 9.5 percent, and there is no assurance that a fax actually arrives or is confidentially maintained.

The Gartner Group determined that approximately 70 percent of all computer input is the result of someone else's computer output. Among all electronic communications, EDI is the only form that does not require human intervention. Claims, for example, are directly and immediately transferred into the payer's system. There is no need for costly key entry. Key-entry errors (estimated at one in every 600 keystrokes) are eliminated. When the claim has been adjudicated, both the payment and remittance advice can be issued electronically. The payment can be directly deposited into the provider's account and the remittance advice electronically "posted" to the accounts receivable system.

Instead of contributing to the growing incidence of carpal tunnel syndrome, EDI allows accounts receivable staff to spend more time resolving exceptions. The use of EDI reduces costs, increases accuracy, and through the use of an acknowledgment process, assures delivery to the intended recipient. If the reduction of labor isn't enough of an incentive to implement EDI, consider the time value of money. Medicare claims are settled 14 days sooner if the provider exchanges claims and remittance advice electronically. Consider, for example, one Colorado hospital with annual revenues of \$350 million, half of which is generated through Medicare. The time value of this money invested at 6 percent for 14 days is more than \$400,000. Add to that the ability to expedite secondary billing by 14 days, and as the saying goes,

"Soon you're talking real money."

According to David Schinderle of St. Joseph's Health System, a seven-hospital, 1,800-bed system in California, "SJHS has reduced its accounts receivable days outstanding from 80 to 56 and has reduced the cost of secondary billing from \$4 per claim to 70 cents per claim." Cleveland Clinic Foundation has implemented EDI for Medicare Part B claims, which has eliminated a six-week backlog, reduced the staff by 10.5 FTEs, and cut the number of Medicare-related calls from 3,600 to 1,000 per week. The Work Group on EDI (WEDI), created by the Health and Human Services secretary under the Bush administration (see glossary below), estimates the cost reduction associated with claims at 80 cents to \$2.30 per claim, with an additional savings of \$1 to \$2 for each remittance advice or payment.

An even greater advantage of EDI is that every participant supports a single medium of exchange. Think of it, a *single* file definition to electronically communicate claims to *every* payer! Perhaps your reaction is, "In whose lifetime? I've got an electronic claims system now, but it only talks to X, Y, and Z."

Legislation passed as part of MinnesotaCare in-

cludes a section concerning administrative simplification. Payers, providers, clearinghouses, and employers doing business electronically are required to support the ASC X12 standards for claims, remittance, eligibility, and enrollment information six months after the Minnesota commissioner of health approves a standard implementation guide. In addition, the Legislature established the Minnesota Center for Healthcare EDI (MCHE) as a nonprofit organization to provide education and serve as a resource center for health care EDI. MCHE is not a state agency, but a part of the Minnesota Health Data Institute, a public-private partnership between the Minnesota Institute for Community Health Information and the Minnesota Department of Health.

In addition to offering monthly courses, MCHE was charged with helping create and implement guidelines for use in Minnesota. MCHE is working on a draft guide for professional claims, which it will submit to the public for comment and review. Concurrently, several organizations have agreed to test an actual implementation to assure that all functional requirements are met before the guide is submitted for final approval. MCHE anticipates that a final document will be submitted to the health

GLOSSARY OF TERMS

ANSI: American National Standards Institute—the organization responsible for establishing many national standards, including business data exchange. Both X12 and HL7 are accredited standards committees (ASC) of ANSI.

ASC X12: American Standards Committee X12—the committee responsible for defining the requirements for the exchange of data between business partners.

EC: Electronic commerce—the use of electronic technology in commerce. Electronic commerce includes such technologies as bar coding, electronic data interchange, fax, video conferencing, and smart cards.

EDI: Electronic data interchange—the computer application to computer application exchange of data in a standard format between trading partners. EDI is generally considered the medium of exchange between one organization and other external organizations.

HL7: Health Level Seven—an accredited committee of ANSI focused primarily on standardizing the format of data exchanged within a health care system, such as admitting, discharge, and transfer data.

Transaction set: A term used to define the standard configuration of data associated with a particular need. Transactions are often equivalent to a single paper document. Transaction Set 810 is defined as an invoice. However, some transactions may serve multiple purposes. Transaction Set 835 may generate a payment order (electronic funds transfer) and/or a remittance advice.

WEDI: The Workgroup on Electronic Data Interchange (WEDI) was established in November 1991 to recommend ways to reduce administrative costs in the nation's health care system. A voluntary, public-private task force, WEDI developed an action plan to streamline health care administration by standardizing electronic communications across the industry. WEDI has published two reports, the "1992 WEDI Recommendations" and the "1993 Report on the Workgroup for Electronic Data Interchange." WEDI is governed by representatives from consumer organizations, government, payers, providers, standards organizations, and vendors. WEDI has several technical advisory groups, including Education, Legal, and Implementation.

commissioner in January 1996.

As you'll discover in the second article of this series, "Two for the Show: The Vision of EDI and Electronic Commerce," coming up in the November *Minnesota Medicine*, EDI is not just for claims, payments, eligibility, and enrollment, but also supports nearly 300 different business transactions, including purchase orders, invoices, payments, test results reporting, and coordination of benefits. The final installment, "Three to Get Ready: How to Implement EDI," will cover the basic hardware, software, and human resource requirements for implementing EDI in your organization. **MM**

For more information on the Minnesota Center for Healthcare EDI, contact Sue Chapin-Strike at 612/228-4381.

Sue Chapin-Strike is director of the Minnesota Center for Healthcare EDI. As a faculty member for several organizations, including the Health Industry Business Communications Council, the Healthcare EDI Coalition, the Health Information Management Systems Society, and the Data Interchange Standards Association, she has delivered more than 40 seminars nationally on health care EDI. She has contributed articles to several magazines and journals, including EDI World, for which she served as a contributing editor for more than two years.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine
Internal Medicine
General Surgery

OB/GYN
Otolaryngology
Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469

OUTPATIENT PSYCHIATRIST

HealthPartners is seeking an outpatient, BE/BC psychiatrist challenged by innovations in team-based, interdisciplinary psychiatric care. HealthPartners' Psychiatrists practice in an evolving organized care system with opportunities to work closely with primary and specialty care physicians as well as mental health professionals from a variety of backgrounds. Specialty interests in affective and anxiety disorders, and disability management are also sought.

HealthPartners staff division was established in 1957 as a staff model HMO offering its physicians a balanced lifestyle, excellent salaries and a generous benefit package that includes paid malpractice.

Psychiatrists will join a department of 15 full time psychiatrists and 80 clinicians that provide service in adult and child, mental/chemical health and health psychology for over 250,000 HealthPartners members. To inquire, please call (612) 883-5337, 1-800-472-4695, or send CV to: **HealthPartners**, Physician Services, Attn: Ann Mliner, 8100 34th Ave. So., P.O. Box 1309, Minneapolis, MN 55440-1309.

HealthPartners' mission is to improve the health of our members and our community.

EO/AA Employer



HealthPartners

Reasons you should **not** attend AMA's October 28 Innovative Financial Strategies Seminar:



- 1** You know your financial plan is so complete that you are not at all concerned about taxes, inflation or retirement.
- 2** You are positive that your present investment allocation is taking full advantage of market performance.
- 3** You are confident that all has been done to reduce investment costs and taxation to maximize your retirement nest egg.
- 4** You have already taken advantage of every opportunity to minimize the largest tax you will ever pay – federal estate tax.

But... if you are concerned about taxes, inflation and retirement and want to know more about the science of winning investment strategies, this seminar is for you.

As your premier broker of high value services, Minnesota Medical Business Resources is sponsoring this AMA seminar, already attended by over 5,000 physicians. The AMA Investment Advisory Seminar provides unbiased, professional insight to help you build a better financial plan.

The cost to attend is just \$119.00 for MMA members, \$149.00 for non-members. Spouses are invited to attend free of charge.

800-298-6627

Seating is limited for this full-day seminar so call today to reserve your place on Saturday, October 28th.

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A business corporation
of the MMA and HMS.*

SCHWARTZ

(continued from page 7)

The Primary Care Shift

From Schwartz's perspective as an oncologist, one of the most significant changes fostered by managed care is its emphasis on primary care physicians as "gatekeepers" to hold down costs. Schwartz doesn't argue with the contention that seeing a specialist adds costs. "The question is, are those appropriate costs because necessary things are being done, or inappropriate costs caused by overutilization of services?" He doesn't claim to have the answer and doubts that anyone does. "But what I like to believe is that when you see a specialist, costs go up because you're receiving appropriate diagnostic tests or treatment," he says.

The gatekeeper approach creates some tension between specialists and primary care physicians. In addition, the federal government's Resource-Based Relative Value Scale has also

put pressure on those relationships, says Schwartz. "That wound is still there, and it has to be healed for physicians to work together and survive in this market. If we're still fighting among ourselves, that's not going to allow physicians to come together in order to deal with the demands of the marketplace."

Joining the Fray With MSP

The demands of the marketplace convinced Schwartz and colleagues in six other specialty groups to form a clinic without walls in early 1993. The original partners in Minnesota Specialty Physicians (MSP) represented seven specialties. Schwartz says they chose a single group in each specialty for two reasons: to allay antitrust concerns and to establish some criteria and protocols that future partners would adopt when joining MSP. "It was easier to develop ways of relating to the marketplace if we had only one group per specialty," Schwartz explains. MSP now includes 22 shareholders in 16 specialties, representing 220 physicians in 110 practice sites in Minnesota and western Wisconsin.

The relationship among the partners in MSP goes beyond maximizing the basic economies of scale. To deliver what the marketplace demands—cost-effective care with quality that can be measured—MSP members share a common information system, conduct outcomes and patient satisfaction studies, and provide "one-stop shopping" for a broad range of specialty services.

Schwartz estimates that 80 percent of services provided through MSP are under some form of managed care. But he says that MSP has not yet generated a unique referral pattern. "It may in the future because of its potential relationships with primary care groups or contracts that result in preferential referrals, but it hasn't at this point," he says.

MSP has been aggressively independent, but Schwartz foresees more collaboration in the future. "We need to form relationships with primary care. That's the Achilles' heel of MSP. It cannot continue to be strictly a specialty organization," admits Schwartz. Recently, MSP formed a

joint venture, called Minnesota Quality Care Network, with 65 primary care doctors at Fridley-based Columbia Park Medical Group and 24 at Quello Clinic in Bloomington.

Schwartz also says MSP has to develop stronger relationships with managed care organizations, by using a "physician-directed" approach. "It's time to not just look at the classical relationships, but at what the Buyers Health Care Action Group* is looking for," he says. BHACG, an influential health care buyers coalition, recently announced plans to create a system that bypasses health plans as intermediaries and allows employees to buy care directly from doctors.

That means staying relatively independent. "If you can provide high-quality care, measure it, and show it to the marketplace, I think there is a place for groups such as ours [Minnesota Oncology Hematology] and MSP to survive without necessarily being purchased by any particular system," Schwartz says. "That adds to the balance and competitiveness of the marketplace."

The Next Generation

At 53, Schwartz is striving to maintain balance in his own career, but he admits that the management aspects of his practice will likely crowd out the clinical side eventually. "But 10 years from now I see myself still having some role in the practice of medicine," he says.

Meanwhile, he's pleased to see his commitment to medicine carried on through his son David, a resident at Mayo and one of Schwartz's three adult children. "I feel good about him going into medicine," he says. "If you go into medicine for the right reasons—not financial, but patient care—I think it's still the best profession to be in." MM

Thomas Allen is a Minneapolis-based free-lance writer specializing in health care topics.

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

*Formerly Business Health Care Action Group.

What obstacles keep you from having the financial security you want ?



Is it...

- ✓ **a lack of time to adequately examine your needs and research the best possible solutions?**
- ✓ **confusion, as endless numbers of brokers, agents and planners approach you?**
- ✓ **uncertainty regarding the quality of financial planning techniques and products available?**

Upcoming Seminars:

October 17, 8am-9:30am

New options that make your qualified plan simple to administer while retaining investment choice.

November 16, 6pm-7:30pm

Strategies to maximize retirement income by decreasing your tax burden.

January 17, 6pm-7:30pm

Practice Succession Planning.
What happens to my practice in the event of death or disability?

Space is limited. Call now to reserve your seat.

MPIA helps you overcome the obstacles because:

- ✦ MPIA does constant research and incorporates individuals who are the very best at understanding your concerns and knowing the solutions available.
- ✦ MPIA has carefully chosen an elite group of local financial professionals committed to serving the medical community with quality and integrity.
- ✦ The MMBR Seal lets you know that the services and products of MPIA have met specific standards of quality and have survived the scrutiny of your peers.

MPIA seminars provide vital information that will help you overcome obstacles to your financial security.

For assistance with your insurance or financial needs or to reserve your place at these seminars, please call MPIA at (800) 298-6627.

MPIA
MINNESOTA PHYSICIANS
INSURANCE AGENCY
A MMBR Company

PRIMARY CARE

(continued from page 14)

call, have time for research, teaching, and family," he says.

As in urban areas, recruitment and reimbursement deficiencies are pushing rural practices to join larger groups. Gateway Clinic feels the pressure to affiliate, but it plans to stay independent and get the benefits of a bigger clinic by negotiating discounts on fee-for-service by specialists. The key, says Christensen, is a good marriage between a primary care group and a subspecialty group. "Primary care is a cost center, not a money-maker. Primary care docs do better in groups of 25 or more with money coming in from subspecialists. You need a multispecialty 'combined return' to even things out."

Gateway has decreased its risk by jumping into a larger pool, Northstar Physicians Plan, 80 primary care physicians in the Duluth area who share risk when contracting with managed care health plans.

"Now we don't get beat up so bad," Christensen says.

Supporting Actors

Particularly under managed care, allied health professionals are often touted as a solution to the rural primary care shortage. Despite the potential benefits they offer, however, nonphysician providers also pose a threat. Some physicians fear nurse practitioners, physician assistants, and mental health specialists may lessen the need for primary care physicians because, as one observer put it, "Seventy percent of all primary care problems can be handled by nonphysicians." Other pessimistic observers suggest allied health professionals could do considerable harm to the finances and morale of primary care physicians. Allies could, they say, refer directly to specialists. But such dour forecasts are more often voiced on the coasts. In Minnesota, nonphysician providers appear to be a welcomed addition to the team, rather than a threat.

The Duluth Clinic is building its integrated network pyramid on a

foundation of primary care doctors reinforced with what they call "mid-level practitioners." The clinic, like others, finds allied health professionals particularly appropriate in rural settings, where doctors may be overwhelmed, in short supply, and hard to recruit.

"[Allied providers] are an appropriate class of providers for rural Minnesota. They have the skills to augment what we do here," says Blue Earth's Cahill, who expects the female nurse practitioner he just hired to attract more patients to his practice.

To those who plan to rely heavily on allied health professionals, especially to overcome rural doctor shortages, Christensen says good luck. "They burn out as fast as doctors. They're not crazy. They don't want to live in a rural area any more than doctors do."

Still, Christensen admits that allied providers give primary care doctors time to do research and teach. "They can enhance a physician's practice," he says, "but they're no panacea."

In some cases, the time it takes to supervise allied health professionals negates possible cost savings. And many patients prefer to see a physician, although acceptance of allied health professionals is generally good and improving. Heavy use of allied professionals does not necessarily lead to better, more cost-efficient care, Christensen cautions. "The more providers you have, whether they're doctors or allied health professionals, the more spigots you have tapping the capitated keg."

Allies have a place in urban settings, too, says Bethesda's Asp. "They can see more routine cases, which means physicians see the more complex cases. However, Asp points out, physicians who rely heavily on allied health professionals are under the most pressure to see lots of pa-



tients, a downside to managed care.

Primary physicians may just have to share some of the limelight with allied health professionals, much like specialists have had to share some with primary care doctors, argues

those patients, you'd never have time for surgery. Why not just see the uncommon or difficult cases?"

That's fine, says Christensen, but watch out for "primary care-itis," the notion that, "Gee, I can do all these things."

Not referring enough to specialists is a risk of managed care, agrees Mayo's Poland. "Directly linking primary care income to referral behavior is dangerous," he says. Poland decides whether to refer based in part on patient temperament. "If they cannot live with uncertainty, refer them," he advises. "Err on the cautious side. If they want a specialist, get them one."

On the other hand, most specialists appreciate when primary care screens out cases they don't really need to see. "Specialists are almost always overwhelmed in a rural area," says Cahill.

Not only are primary care doctors feeling tension with specialists, they may also feel it with their patients. As powerful third parties expand their influence over medicine, some physicians argue that managed care drives a wedge through the doctor-patient relationship. Patients don't understand why they can't see a specialist. As patients become more savvy, they suspect the physician's decision not to refer is financially, rather than medically, motivated.

Cahill says he's frequently confronted with frustrated patients who want to see a specialist or go to a particular facility and don't understand why they can't. "They don't read their [health] plans," he says. "They just know they want to see a dermatologist for their acne."

Some primary care docs complain that managed care pressures them to balance patients' needs against the health plan's financial well-being, an ethical conflict that can make physicians more vulnerable to malpractice suits. "It's a serious issue," says Poland. "There have been lawsuits [concerning] patients

who were denied access to specialists."

It's always been a serious issue, agrees First Plan's Hiza, but not necessarily managed care's fault. "Managed care does not cause litigation," he says. "You can still be sued for practicing good medicine. I'm disturbed by the notion of practicing defensive medicine."

Christensen says managed care need not add to liability. As long as the physician uses sound medical judgment and documents decisions, managed care or capitated efficiencies should not pose a litigation problem. "Documentation will show the actions taken were made with the patient's best interest in mind, not the plan's, or the doctor's bottom line." Minimize vulnerability, he suggests, by writing capitated agreements that allow the doctor to do what needs to be done.

Poland doesn't like what he sees happening to the doctor-patient relationship beyond Mayo's buffering walls. "It used to be just the doctor and patient in the exam room," he says. "Now the bottom line is in there, too. Medicine becomes an adversarial triangle between the primary care doctor, the patient, and the payer." In medicine, as in love, triangles create complications. "I would be frightened to leave Mayo and be in private practice," Poland says. "I'm fortunate that here I'm encouraged to spend as much time as I need with each patient. That's just not happening elsewhere where the emphasis is on 'throughput' and productivity."

Still, Poland says, Mayo does feel managed care pressures. "We're just feeling it twofold instead of tenfold. But we have not compromised one-on-one time with the patient."

Neither has Moose Lake's Gateway Clinic, according to Christensen. "There may be clinics where that's happening," he says, "but there's no clock on the wall here." Christensen says if anything, fee-for-service encourages assembly-line medicine because the more you see, the more you make, unlike salaried practices. "To those with the key to Fort Knox, we have to ask, 'Are you doing unnecessary things?'"

continued

"It used to be just the doctor and patient in the exam room. Now the bottom line is in there, too. Medicine becomes an adversarial triangle between the primary care doctor, the patient, and the payer."

—GREG POLAND, M.D.

Hiza. "There are lots of things we [primary care doctors] see that we don't need to see. A nurse practitioner can take care of a simple otitis media. Same with well-child checks. A lot of what we do is reassure people. Allied professionals can do this, too."

Wearing the Black Hat

Managed care casts primary care physicians in the role of bad guy when it comes to referral relationships with specialists, who don't like having their access to patients "managed" and don't appreciate being "curbsided"—asked for a recommendation but never referred to.

"Managed care and capitation definitely create adversarial relationships between primary care and specialists," says First Plan's Hiza. Communication is the key, but that can be difficult. It's not easy to criticize, even constructively, another doctor for what you consider an inappropriate referral or poor follow-up. Like a husband and wife who don't talk about it, resentment builds on both sides.

"It's an onerous job being a gatekeeper," Hiza says. "Specialists are afraid the primary care doctor won't refer. The primary care doctor is afraid he'll be accused of not referring soon enough. I had an ENT tell me there are 26 causes of ear pain and you need an ENT to tell one from the other. I told him, 'If you saw all

Perception Is Reality: Gatekeeper or Coordinator?

Some physicians question whether third-party payers use the term "gatekeeper" to put an adversarial spin on the doctor-patient and doctor-

doctor relationships. The word implies restricting access rather than coordinating it. Whatever the case, primary care physicians can help smooth over the negative implications of being a "gatekeeper" by educating and communicating with

patients, especially patients who feel they have been denied care for financial reasons.

Basically, primary care physicians concur, the key is to practice good medicine: Help patients understand why a decision was made. Stay in touch with patient needs. Discourage patients from requesting unnecessary tests or consults and explain why. Follow up with patients. Help the patient and family interpret information. Know when to refer. Avoid over-referral for liability protection and under-referral for financial reasons.

Like it or not, managed care has placed primary care center stage. With higher salaries, more opportunities, and greater prestige come the tensions and hassles of being cast in a leading role. Whether the positives outweigh the negatives depends on your perspective, philosophy, and performance. MM

Free-lance writer Howard Bell has just moved to La Crosse, Wisconsin, from Duluth.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. —and that's not a line, it's a **promise**.

Opportunities now available for board-certified/board-eligible physicians:

- **Family Practice**
- **General Surgery**
- **Obstetrics/Gynecology**
- **Internal Medicine**
- **Otolaryngology**
- **Occupational Medicine**
- **Urgent Care**



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
612-885-6224
1-800-842-6469



ASPEN
Medical Group 

Internal Medicine

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 160 professionals who offer care at 13 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

People and Places Making Medical News

People

Charles Bolles Bolles-Rogers Award

The Hennepin Medical Society has given **Paul F. Bowlin, M.D.**, the 1995 Charles Bolles Bolles-Rogers Award. Each year the award is given to a physician who, in the opinion of the members of the Hennepin Medical Society, has become an outstanding example of the profession through contributions in medical research, achievement, or leadership.

Bowlin is a long-time member of the Fairview Southdale staff. He served as director of medical affairs at Fairview Southdale from 1986 to 1992, and then served as medical director of development for Fairview Health System from 1992 to 1994. His community positions include six years on the Metropolitan Health Board ending in 1983; three years as president-elect, president, and chair of the board of the Hennepin Medical Society ending in 1987; and a current position as the only non-full-time faculty member of the University of Minnesota Medical School Admissions Committee.

Allina Vice President

Allina Health System has named **David B. Pryor, M.D.**, system vice president of Information Services. Before joining Allina in September, Pryor was president of the New England Medical Center in Boston. He is a cardiologist with an extensive background in administration, clinical practice, and information systems.

Leukemia Society of America Scholarship

Catherine Verfaillie, M.D., associate professor of medicine at the University of Minnesota Health System, recently received a \$200,000 Leukemia Society of America Scholarship to support her

research into the regulation of blood cell production in the bone marrow cavity. Verfaillie's research could lead to new treatments for chronic myelogenous leukemia.

The Leukemia Society of America Scholarship is the society's most distinguished award. The scholarship program is noted for funding and supporting major research in genetics, virology, immunology, and other fields.

HCMC Ambulatory Care Medical Director

Hennepin County Medical Center has named **Jean Barton, M.D.**, medical director for ambulatory services. Barton is also Peds Clinic medical director.

In her new role, Barton will facilitate the clinical operations and delivery of patient care in the ambulatory clinics in accordance with HCMC and Hennepin Faculty Associates policy. The position includes being a liaison with several committees; monitoring, altering, and developing standards of service; serving as a resource to clinic medical directors and assisting in accomplishing their goals; and working with the ambulatory services administrator and HCMC's medical director in matters of space, resource, and facilities utilization.

Weigelt-Wallace Award

Three physicians are the first recipients of a new award named after Minnesota physician **John Weigelt, M.D.**, chair of the St. Paul-Ramsey Medical Center Surgery Department and a professor and vice chair of the Department of Surgery at the University of Minnesota. The Weigelt-Wallace Award, established at the University of Texas, recognizes exceptional examples of patient care showing "extraordinary dedication and sacrifice on behalf of medicine and

mankind." The award's benefactor, a Texas philanthropist, was inspired by Weigelt, then a professor of surgery at UT Southwestern, and **Mark Raymond Wallace, M.D.**, currently a commander at the U.S. Naval Medical Center in San Diego, California. In 1991, the two worked from opposite sides of the globe via satellite communications link to save the life of an American soldier wounded in a February 1991 SCUD missile attack on his barracks in Saudi Arabia.

J. Andy Sullivan, M.D., and **David Tuggle, M.D.**, both of the University of Oklahoma Health Sciences Center, received the award for risking their lives entering the Alfred P. Murrah Federal Building in Oklahoma City after the explosion last spring to amputate the leg of a woman who was trapped in the building's basement. **Angus Wallace** (no relation to Mark Raymond Wallace) of University Hospital, Queen's Medical Centre in Nottingham, England, also received the award. He operated on a fellow airline passenger suffering from a collapsed lung, using a scalpel and local anesthetic from the 747's medical kit, a bottle of water, a rubber urinary catheter, scissors, and a coat hanger sterilized in five-star brandy.

Places

BCBSM Expanding

Blue Cross and Blue Shield of Minnesota is planning to expand its Eagan campus in coming years, including adding about 1,000 employees and 400,000 square feet of new office space. BCBSM is already one of Minnesota's largest employers; with more than 3,000 employees, it ranks just behind West Publishing and about even with Northwest Airlines.

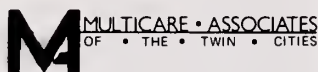
The planned expansion includes

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Urgent Care
Internal Medicine**

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



four 100,000-square-foot buildings near BCBSM's RiverPark building, which the company bought in March after leasing space for three years. Before it can begin construction, Blue Cross must get the required environmental permits and approval from its board of directors. The first building may go up in the next year or two, according to Karl Oestreich, Blue Cross spokesperson.

"This is part of our long-term effort to consolidate our Eagan operations and anticipated growth over the next five to 10 years," said Oestreich in a *St. Paul Pioneer Press* article. The company has added about 100,000 members this year to its nonprofit health insurance operations business, bringing its membership total to 1.4 million, he said.

**St. Paul-Ramsey Starting
Emergency Residency**

A three-year medical residency program designed to train physi-

cians in an emergency medicine specialty will start at St. Paul-Ramsey Medical Center in July 1996. The Ramsey emergency medicine residency program, designed to accept eight students per year for a three-year total of 24, will train physicians in all aspects of emergency medicine. The program is one of two emergency medicine residencies in the Upper Midwest that graduate a total of 18 physicians per year.

"There is a shortage of residency-trained emergency physicians in the nation, and our best projections are that this shortage will continue," said Robert Knopp, M.D., director of education for the emergency medicine department and residency application coordinator. "The creation of this new medical residency will help alleviate the shortage of board-certified emergency medicine physicians."

**NIH to Monitor 'U' Research
Grant Spending**

The National Institutes of Health has designated the University of Minnesota an "exceptional organization," which means NIH will be monitoring the university's spending of federal grant money to minimize risks "associated with poor business management practices." The designation stems from the discovery that members of the university's Surgery Department illegally diverted nearly \$2.5 million in federal grant money for nongrant purposes.

NIH will continue to fund research but will work with the university to assure the money is spent properly. It has asked the university to reach a compliance agreement by December 1 that specifies steps to establish the university's fitness to continue to receive and manage NIH research grants. NIH contributes about \$100 million in grants each year for more than 500 university research projects. It is the university's largest source of research money.

University officials argued that

the designation is inappropriate because they already are working to correct any problems.

'U' Receives Research Grants

The University of Minnesota Vascular Diseases Center has received a five-year, \$731,000 grant from the National Institutes of Health, which also named the center one of 15 national Centers of Excellence. The designation should help the center win additional research money and initiate new studies, said Alan Hirsch, M.D., assistant professor of medicine and the center's director. The University of Minnesota Clinical Associates, a group of university administration and medical faculty, matched the NIH grant with a one-year, \$100,000 award.

The federal Centers for Disease Control and Prevention has awarded the University of Minnesota a \$770,000 grant to conduct a three-year study on the factors and experiences that determine the levels of violence among adolescents. "What we are interested in understanding are what are the factors, forces, and life experiences that promote or reduce the likelihood of violence among adolescents," said study leader Michael Resnick, a professor of maternal and child health in the university's School of Public Health.

The research will separate the factors that lead to violence between people, as well as self-directed violence, he said. It also will investigate the positive influences that adults, school, and peer group interaction have on the adolescents who are part of the study.

Researchers will survey 19,000 adolescents, their parents, and friends, and compare the results with an earlier benchmark study conducted by university researchers between 1988 and 1990 on health and risky behavior and relationships among 14,000 American Indians nationwide.

Socioeconomics

State Receives Grant for Senior Health Care Improvement

The Minnesota Department of Human Services has received a \$1.2 million grant from the Robert Wood Johnson Foundation for a federal demonstration project that aims to ensure quality and control cost and to make it easier for low-income seniors to use the health care system. The six-year grant will support the Long Term Care Options Project, the first state program to coordinate Medicare and Medicaid benefits. In April, the U.S. Department of Health and Human Services granted Minnesota a waiver from federal Medicaid rules, which allowed the project to move forward.

Under the project, seniors who are already enrolled in a managed care plan through Medicaid and who also are eligible for Medicare could choose a health care plan that would provide a full range of services now covered by both Medicare and Medicaid. The option is intended to better coordinate seniors' needs, giving them one point of access for all their care, according to Pamela Parker, project director. Up to 4,000 people in the Twin Cities metropolitan area will be included in the demonstration project, which will begin in early 1996.

HealthSystem Minnesota Eliminates Senior Management Positions

HealthSystem Minnesota announced in September a restructure of senior management that included the elimination of nine senior management positions—a move that will save the organization about \$1 million a year in salaries and benefits. The new structure is intended to further consolidate Methodist Hospital and Park Nicollet Clinic operations and streamline management reporting to Chief Executive Officer James Reinertsen, M.D.

The nine eliminated positions include senior vice president and

chief operating officer, HealthSystem Minnesota, held by Terry S. Finzen; senior vice president and chief administrative officer, Park Nicollet Clinic operations, held by Mark S. Fisher; and vice president and chief financial officer, held by Steven F. Martin. The six other eliminated positions are senior management in hospital and clinic operations. No other cuts or layoffs are planned at this time. Reinertsen stressed that the positions were eliminated *not* because of poor job performance, but because the organization needed to streamline authority.

NWNL, HealthPartners to Form Alliance

Northwestern National Life has signed a letter of intent to form a strategic alliance with HealthPartners that will allow the two groups to cross-market their employee benefit products. NWNL sales agents would sell HealthPartners' HMO products in addition to their own, and HealthPartners would sell NWNL health policies and life and disability insurance underwritten by NWNL.

Before it can be finalized, the agreement must be negotiated and approved by the companies and regulatory agencies. As *Minnesota Medicine* goes to press, the companies expect to sign a definitive agreement by late September.

Groups Form New Physician Network

Minnesota Specialty Physicians, Quello Clinic, and Columbia Park Clinic have formed the Minnesota Quality Care Network (MQCN), encompassing more than 300 specialty and primary care physicians. The groups will continue to function independently, but together they intend to contract with health plans and to eventually contract directly with employers under a health care model currently being developed by the Buyers Health Care Action Group, according to network officials.

Quello Clinic has 24 primary care physicians at eight sites.



"I found the advantages of a large group practice with a small community lifestyle."

Charles R. Bricker, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a 55 year-old, multi-specialty group of 115+ physicians, has several practice opportunities throughout its practice locations. Currently, we are seeking:

WENATCHEE/EAST WENATCHEE

- Family Practice w/OB
- Ophthalmologist (w/retina)
- General Internist • Urgent Care

MOSES LAKE/OMAK

- Pediatrician • Orthoped
- Surgeon (General)
- Radiologist (General)

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director •

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711 ext. 5203



Wenatchee Valley Clinic

Fridley-based Columbia Park Medical Group has 65 primary care physicians, three clinics, and two rehabilitation centers. Minnesota Specialty Physicians is an affiliation of 220 specialty physicians from 22 groups representing 16 different specialties.

Blue Cross Loses Contract to Process Doctors' Medicare Claims

Blue Cross and Blue Shield of Minnesota has lost its contract with the federal government to process Medicare claims from physicians in outstate Minnesota. The Health Care Financing Administration, the federal agency that runs the Medicare program, gave the contract to Virginia-based MetraHealth, a firm currently being acquired by Minnetonka, Minnesota-based United Health-Care Corp. MetraHealth was already processing claims from physicians in the Twin Cities and Rochester areas. Blue Cross will continue to process Medicare

claims for the state's hospitals and nursing homes.

Rates, Trends, Data

Minnesota Immunizing 81 Percent of Children by Age 2

Eighty-one percent of Minnesota children are fully immunized against seven major diseases by age 2, according to a Centers for Disease Control and Prevention survey based on information collected in 1994. Eleven states had a higher percentage of children vaccinated by age 2.

"It's not good that we have *any* children in this state that are unprotected," said Mary Sheehan, manager of the acute-disease prevention services section of the Minnesota Department of Health, in the Twin Cities *Star Tribune*.

The study, based on an extensive telephone sampling of parents in each state and record checks with their children's health care providers, found that 75 percent of children nationwide are fully vaccinated by age 2. Vermont ranked the highest with 88 percent, and Michigan the lowest at 61 percent. Wisconsin is in the middle at 76 percent. Minnesota had the highest rate of vaccination with MMR at 95 percent.

The CDC conducted the study to identify states with high rates so other states can learn from them.

Law & Policy

MCLU Sides With Tobacco Industry

The Minnesota Civil Liberties Union is filing a friend of the court brief that sides with the tobacco industry and a Preston, Minnesota, convenience store that has sued the city over its ordinance banning tobacco advertising in retail stores. The MCLU said the ordinance violates the constitutional right to free speech.

Preston became the first city in the nation last year to pass such an ordinance. The city stipulated that tobacco advertisements in grocery and convenience stores can only

include basic information and must be printed in black type on a white background, with no logos or promotional materials. A local convenience store, backed by tobacco interests, has sued Preston over the ordinance. The MCLU plans to file its brief this month, according to an article in the Twin Cities *Star Tribune*.

Nurse Anesthetists Add Abbott Northwestern to Lawsuit

The Minnesota Association of Nurse Anesthetists is adding Allina's Abbott Northwestern Hospital to its \$280 million federal lawsuit accusing hospitals and anesthesiologists of false billing and Medicare fraud. The association had already filed suit in May against two other Allina hospitals, Unity in Fridley and Mercy in Coon Rapids, and against St. Cloud Hospital, as well as the three hospitals' anesthesiologists. The suit claims the defendants billed Medicare for "services which they either did not perform or which did not qualify for reimbursement under Medicare laws and regulations." It further says, "These services were, in fact, being performed by nurse anesthetists. The nurses association has filed its lawsuit on behalf of the U.S. government, which is also a plaintiff in the action.

Allina Health System says the suit has no merit. "We deny any knowledge of any improper billing at Abbott Northwestern or any other Allina hospital," said Allina spokesperson Sarah Stoesz in a *St. Paul Pioneer Press* article.

Nursing Homes Suing State

The Minnesota Association of Homes for the Aging is suing the state over a new law that cut the rate of increase in payments for nursing home residents covered under Medical Assistance. The suit claims that the reduced rate violates the federal "Boren Amendment" passed by Congress in 1980, which says states must pay nursing homes in a manner that is "reasonable and adequate to meet the costs

that must be incurred." The nursing homes claim care has suffered because they have cut staffing.

Minnesota's new law changes the formula for reimbursing nursing homes. Before July 1, the state paid nursing homes an average of \$92.24 per resident per day. The nursing homes had been expecting an average 6 percent increase in reimbursement, but instead got about a 3 percent increase. Medical Assistance pays for the care of about 93 percent of the nursing homes' residents. The suit, filed in U.S. District Court in Minneapolis, asks that the old payment formula be reinstated.

Medical Research

Cholesterol-lowering Drug Lovastatin May Slow Cancer

Lovastatin, the most commonly prescribed cholesterol-lowering drug, may help treat some cancers, according to University of Minnesota researchers. Their study, reported in the *Annals of Surgical Oncology*, found that the drug, in combination with a conventional anticancer drug, almost wiped out the spread of tumor cells by blocking the cells' production of an enzyme needed to produce cholesterol, which the cancer cells need to thrive.

Researchers found that lovastatin, sold under the brand name Mevacor, significantly slowed the growth and multiplication of liver cancer cells when used alone. In combination with the drug mitomycin-C, it almost stopped the cancer from spreading, increasing the effectiveness of mitomycin-C by as much as 63 percent.

Henry Buchwald, M.D., professor of surgery and senior author of the study, said lovastatin's ultimate role may be to enhance the effect of other anticancer agents against liver, lung, breast, and brain cancer. The research was conducted by Todd Morris, M.D., a former surgery resident who has since moved to Italy.

MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

OCTOBER 1995

Oct. 7 **Orthopedic Symposium** Allina Health System; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-15 **Radiology '95: General Radiology Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis MN 55414; 612/626-7600.

Oct. 13 **Insights and Outlooks** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 13 **Ophthalmic Plastics Course** Phillips Eye Institute and Allina Health System; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14 **Current Trends in Ophthalmology** Phillips Eye Institute and Allina Health System; Hotel Sofitel, Bloomington, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 18-20 **Thirteenth Biennial Great Lakes Regional Conference: Prevention Strategies for Cardiovascular Disease** Department of Health, NHLBI, and Mayo Clinic; Mayo Medical Center, Rochester, MN. CONTACT: Kari Ptacek, Section of Continuing Medical Education, Mayo Foundation, 200 First Street SW, Rochester, MN 55905; 507/284-2085.

Oct. 18-20 **Internal Medicine Review** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 20 **Commitment to Breastfeeding: Overcoming Challenges** The Breastfeeding Center of Methodist Hospital; Park Nicollet Clinic, St. Louis Park, MN. CONTACT: The Breastfeeding Center, Methodist Hospital, PO Box 650, Minneapolis, MN 55440; 612/993-3123.

Oct. 20 **The Fourth Annual Conference for Planners of CME** Minnesota Medical Association Committee on Accreditation and Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Jane Phillip, Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

Oct. 22-23 **International Symposium on Innovative Therapies (ISIT): Lysosomal Storage Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Minneapolis, MN 55414; 612/626-7600.

Oct. 26-27 **Annual Fall Seminar—Obstetrics and Gynecology** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 27-28 **New Ulm Fall Seminar** Allina Health System; Holiday Inn, New Ulm, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 28 **The Ninth Annual Tutorial on Pediatric Cardiology for the Primary Practitioner** The Children's Heart Clinic, Minneapolis, MN. CONTACT: Denise Zang, 2545 Chicago Avenue South, #106, Minneapolis, MN 55404; 612/871-4660.

Oct. 30-31 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

NOVEMBER 1995

Nov. 3 **Cancer Center Program: Head and Neck Cancer** University of Minnesota Continuing Medical Education; Weisman Art Museum, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Nov. 3 **E.T. Bell Fall Pathology Symposium** University of Minnesota Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Nov. 4 **1995 Fall Anatomic Pathology Seminar** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Jennifer Stendahl, Minnesota Society of Pathologists, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/362-3737.

MMA-Accredited CME Sponsors

• The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor CME activities for local physicians. • Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating the amount and category of credit for CME activities. • CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." •

The MMA Committee on Accreditation and CME has recently granted initial accreditation to Hennepin County Medical Center, Minneapolis, and has reaccredited the following CME sponsors:

- Austin Medical Center, Austin
- Fairview Ridges Hospital, Burnsville

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



Call Stephanie Jussila, Physicians Services I-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

*COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes*

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C.F.
anderson
COMPANY, INC.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., October 15 for December ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Excellent opportunity for those physicians seeking freedom from call and hospital responsibilities. Patient base is primarily young adults and children. Attractive hours and compensation. Send inquiries to Robert Kantor, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441. (*7/95-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine, (oncology, pulmonology, and nephrology), family practice, ophthalmology, and ob/gyn. Excellent salary/benefits package includes guaranteed salary the first year with full partnership after one year; health, dental, and life insurance; pension/profit sharing; and relocation assistance. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Internist...

Want to share call with 8 other Internists and live in the Brainerd lakes area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30-physician independent multi-specialty group
- Located in a primary service area of 40,000
- Almost 100% fee-for-service
- Excellent fringe benefits
- Compensation at least what the market pays
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Inquiries from Internists with subspecialty interest in Pulmonology and Rheumatology welcomed.

Call collect to administrator:

- Curt Nielsen
218-828-7105 or
218-829-4901
2024 South 6th Street
Brainerd, MN 56401



Escape From the Ordinary! Needed! General surgeon to work in our thriving rural family practice. Candidate should have skills in C-section, gynecology and laparoscopic surgery. Eight weeks' vacation/CME. Consultants available. Only group in county with three referral centers one hour away. Uniquely situated on I-94 halfway between Madison and the Twin Cities. Small-town pride, excellent 51-bed hospital, great schools and recreation including all water sports, hunting, fishing, cross country and downhill skiing. Cohesive group of caring physicians! Contact or send CV to Gary K. Petersen, Krohn Clinic, Ltd., 610 West Adams Street, Black River Falls, WI 54615; 715/284-4311.

(*9/95-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066.

(9/95-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)



COASTAL
PHYSICIAN SERVICES
OF THE MIDWEST, INC.

Your Private Practice Alternative in the State of Minnesota



- No on-call
- Medical Directorships
- Assured Income
- Group Practice

Brian Nunning

800-326-2782 • FAX: 314-291-5152

3221 McKelvey, Suite 106, St. Louis, MO 63044



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator

Alexandria Clinic, P.A.

610 Filmore Street

Alexandria, MN 56308

612-763-5123

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: family medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates nine branch offices in southeastern Minnesota and staffs affiliate hospital emergency room. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (9/95-R)

Mankato, Minnesota: FP needed to join group of three board-certified family physicians and newly added part-time nurse practitioner and physician assistant in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Ski Steamboat Colorado: Three bedroom, three bath, non-smoking condo. Physician-owned. Sleeps eight. Washer/dryer, fireplace, heated garage, pool, sauna, hot tubs, cable TV, VCR, compact disc stereo. Free shuttles to lifts and town. Saturday to Saturday rentals, 612/427-8510.

*2-10/95



Columbia Park Medical Group

- Family Practice ● Internal Medicine
- Occupational Medicine ● Pediatrics
- BC/BE Specialists

FAMILY PRACTICE: Join group or do Urgent Care with a 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Nine-member department has busy hospital and clinic practice.

OCCUPATIONAL MEDICINE: Three B.C. physicians looking for additional physician to join busy Occupational Health Department.

PEDIATRICS: Seeking fourth pediatrician interested in primary and consultative pediatrics.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Tom Behrend, (612) 586-5882

EMERGENCY MEDICINE

P • S • I • T • I • N • S

IOWA

NORTH & CENTRAL MINNESOTA

- Full- and part-time
- Comprehensive benefit packages
- Paid malpractice
- Professional environments
- Ample time for family and leisure
- Progressive physician-owned group
- Excellent compensation packages
- Various locations
- Reasonable housing in safe communities
- Top-notch school systems
- Quality lifestyles

CALL 1-800 458-5003

Emergency Practice Associates
or send CV to Sheila Jorgensen
P.O. Box 1260, Waterloo, IA 50704

GENERAL SURGEON — BE/BC —

The Department of Surgery at the Mayo Clinic, in conjunction with the Fairmont Clinic, is seeking two broad-based general surgeons to join a Mayo Regional Facility in Fairmont, Minnesota, 120 miles west of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 15-person Mayo-affiliated medical clinic in this town of about 11,000 with a 77-bed hospital and a service population of 45,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise, and excellent salary and benefits. Inquiries:

Michael G. Sarr, M.D.
Department of Surgery
Mayo Clinic
Rochester, MN 55905

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Primary Care Physicians for weeknight, weekend, and holiday coverage at medical center in Rochester. Current BCLS and ACLS required; licensure from any state acceptable. Residents encouraged to apply. We offer flexible schedules and malpractice coverage. Contact in confidence Annashae Corp., Professional Healthcare Staffing, 800/245-2662. *2-10/95

National Company Seeks Physicians—Contractor Basis: Immediate opportunity for licensed physicians in the Minneapolis/St. Paul area to complete insurance physicals on a part-time basis. Make your own hours; competitive pay. Contact Gretchen Michalski, 612/639-8133. 2-11/95

Vice President, Medical Affairs: Small regional health system in medium-sized Midwestern community seeks an experienced medical executive. Progressive managed care environment. Need a visionary who is strategic and quality-focused and has strong administrative/organizational skills. Great opportunity. Call or write to Michael F. Doody, Witt/Kieffer, Ford, Hadelman & Lloyd, 2015 Spring Road, Suite 510, Oak Brook, IL 60521; 708/990-1370, or fax 708/990-1382. 1-10/95

Clarkson Family Medicine opened its doors July 1, 1991. We have filled in the Match Program every year since then and have expanded from a 12-resident program to an 18-resident program in 1995. We have seen our graduates, as a group, score in the top 10 percent nationally on the in-

training exam. We currently have four full-time family practice faculty, one obstetrician, one pediatrician, and full-time behavioral science coverage, including two part-time psychiatrists. In order to provide the training necessary to prepare our residents for rural practice, including extensive obstetrics and procedural experience, we are recruiting two additional family physician faculty. Requirements include practice and/or teaching experience, strong obstetrics background, and a desire to participate in a new, exciting, and growing residency program. Responsibilities and salary are negotiable and based on experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants who use tobacco products. EOE. Send CV and/or letter of inquiry to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, NE 68131; 402/552-2045. 3-12/95

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-12/95

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

Park Nicollet Clinic HealthSystem Minnesota

Urgent Care Department

- BC/BE family practitioners, general internists, or emergency medicine practitioners
- Five positions available; twelve positions filled
- Varied and challenging patient population
- New flexible scheduling options
All considered full-time with same base pay
 - #1 40 hrs/wk, no evenings/no weekends
 - #2 36 hrs/wk, 6 hrs of evenings/weekends
 - #3 32 hrs/wk, 12 hrs of evenings/weekends
 - #4 28 hrs/wk, 18 hrs of evenings/weekends
- A 385 - physician multispecialty clinic
- Contact Patrick Moylan at 612/932-5986
or
Send CV and letters of inquiry to:
*Professional Practice Resources
Park Nicollet Clinic
6500 Excelsior Boulevard
St. Louis Park, MN 55426
or
Fax 612/932-6490*

Medical Director: Interstate Medical Center, affiliated with the University of Minnesota Health System, is a 36-physician multispecialty practice located one hour southeast of the Twin Cities and an hour northeast of Rochester, and is nestled in the bluffs along the beautiful Mississippi River. We are seeking a practicing physician for 50 percent practice, 50 percent medical director duties. Requirements for this position include BC/BE, Minnesota license, minimum one year administrative experience preferred. Competitive salary and benefits package. Respond with a CV or telephone call to Karen Fredrickson, Administrative Assistant, Interstate Medical Center, Highway 61 West, Red Wing, MN 55066; 612/385-4201. 2-11/95

No Assembly Lines Here: FPs, IMs, and ob/gyns at North Memorial-owned and -affiliated clinics don't hand patients off to the next available specialist. Guide your patients through their entire care process at one of our 25 practices in urban and semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs call 800/275-4790, or fax CV to 612/520-1564. 1-10/95

Office Space—Eden Prairie: Excellent visibility. Share entry/restroom with another practitioner. Your own business office, one to four exam rooms, x-ray. Beautifully decorated. Very reasonable with extras. Info packet available. Call 975-0686. 1-10/95

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Jonathan Cohen, M.D., MPH
Director, Urgent Care/Emergency Department (1110)
Veterans Affairs Medical Center
One Veterans Drive
Minneapolis, MN 55417
612-725-2158



An equal
opportunity
employer.

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare system

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine
Internal Medicine
Orthopedic Surgery
Noninvasive Cardiology
Neurology
Pediatrics

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-3745.

STATE FARM INSURANCE COMPANIES

Is seeking a Regional Medical Director who will act as the medical consultant for the North Central Region. This is a great opportunity for a physician who is interested in occupational health as well as working with employees and management on a professional and ethical basis. There are currently 1200 employees in the Twin Cities metro area and 500 employees located outstate.

There must be a willingness to commit a limited number of hours on a weekly basis for the following:

At the Regional Office location:

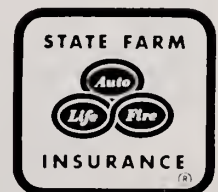
- Review of pre-employment health questionnaires
- Provide input and opinions on employee medical issues

At the physician's office location:

- Conduct middle management and periodic physicals for eligible employees

This position offers flexibility and a very good compensation structure. If you are interested in additional details, please contact Susan Peltan, Regional Personnel Manager, at (612) 631-4241, or send inquiries to State Farm Insurance Companies, 1500 West Highway 36, St. Paul, MN 55161.

Note: We will be moving to our new Woodbury, Minnesota, location in the Fall of 1996.



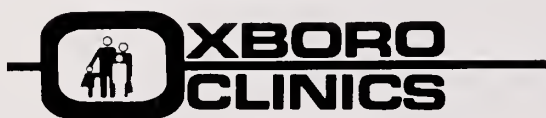
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient, Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469



NORTHERN EXPOSURE

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park. It's setting is not as remote as the popular television series, but you will be exposed to your share of wildlife, lakes, streams and a lot of friendly people working in a 30-physician, multi-specialty clinic — natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd. currently has openings in Family Practice, Internal Medicine, Orthopedics, and ENT. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:

East Range Clinics LTD 

Bill Doran, Physician Recruiter

910 Sixth Avenue North, Virginia, MN 55792 1-800-377-3290 or 218-741-0150

Mesaba Clinic—Hibbing is seeking BC/BE physicians in the following specialties: internal medicine, cardiology, family medicine, general surgery, oncology, ophthalmology, orthopedic surgery, and urology. This progressive 15-physician multispecialty group offers a competitive salary/production incentive and a comprehensive benefits package. Numerous recreational opportunities, nationally recognized public schools, and affordable housing awaits you in this community of 18,000 set in the beauty of the northwoods. Contact the Minnesota Center for Rural Health at 800/997-6685, or the Mesaba Clinic at 218/262-3441. All inquiries will be held confidentially. 1-10/95

OCTOBER 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	68
Aspen Medical Group	60
Audio-Digest Foundation	Cover 2
Brainerd Medical Center	68
Central Minnesota Group Health Plan	66
C.F. Anderson Co., Inc.	66
Chisago Health Services	54
CNA Insurance	19
Coastal Physicians	68
Columbia Park Medical Group	69
East Range Clinic	73
Emergency Practice Associates	69
Fairview Clinic Services	60
Fargo Clinic MeritCare	46
Global Holidays	44
HealthEast	Cover 4
HealthEast Capitol Medical Laboratory	50
HealthPartners	46, 54
Leonard, Street & Deinard	51
Mayo Foundation	69
Medical Protective Company	45
Minnesota Medical Business Resources	4, 41, 55
Minnesota Physicians Insurance Agency	57
Moonlight Home Health Care	70
Multicare Associates of the Twin Cities	62
Norwest Center	51
NSP	Cover 3
Oxboro Clinics	72
Park Nicollet Clinic	70
St. Francis, Inc.	71
State Farm Insurance	71
University of Minnesota	3
Veterans Affairs Medical Center—Minneapolis	71
Webb Financial Group	42
Wenatchee Valley Clinic	63
Whitesell Medical Locums, Ltd.	56

WE SAVE THESE HOSPITALS A LOT OF OPERATING EXPENSES.



THESE HEALTH CARE EXPERTS KNOW THAT THE ENERGY EXPERTS ARE AT NSP.

Hospitals are looking for ways to cut costs and maintain patient comfort and service. And the energy experts at Northern States Power Company are helping them do it.

We can help you with bottom-line savings, by helping you make your lighting, HVAC and other systems more energy efficient.

Our proven service programs...including discount

- Abbott/Northwestern Hospital
- District Memorial Hospital
- Family Practitioners, P.A.
- Health One Mercy Hospital
- Health One Unity Hospital
- Immanuel - St. Joseph's Hospital
- St. Cloud Hospital
- Memorial Blood Center of Minneapolis
- MinnHealth, P.A.
- North Memorial Medical Center
- Northwestern Prosthetics & Orthotics, Inc.
- Park Nicollet Medical Center
- University of Minnesota Hospital and Clinic
- Community Memorial Hospital - Winona



NSP Energy SolutionsSM For Business
1-800-481-4700

rates, audits and cash rebates...are based on years of experience. They're designed to help you save energy, cut costs and maintain the comfort of your patients. That's why when you're selecting an "energy partner," there's just one choice: the energy experts at NSP.

ENERGIZE
Your Bottom LineSM

FREEDOM CAN BE AS SIMPLE AS BREATHING



WE SPECIALIZE IN RESTORING THAT FREEDOM.

Faced with the probability of lifelong ventilator dependency, patients are experiencing a program of intensive care, where many of the unweanable are weaned, and the focus is on gaining independence.

Created specifically to care for patients with chronic ventilator or oxygen dependency, the Prolonged Respiratory Care Unit (PRCU) at HealthEast Bethesda Lutheran Hospital and Rehabilitation Center has gained national recognition through advanced aggressive therapy.

But most importantly, our patients have gained their freedom.



For more information
Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

Scope of services: General Medical Services • Ventilator/Respiratory Care • Wound Care • Neurobehavioral Services • Rehabilitation Inpatient Services • Swallowing Disorder Treatment • Capitol Heights Respiratory Residence • Geriatric Behavioral Care • Pain Management at the **Minnesota Pain Center (MPC)**, located at HealthEast Bethesda Lutheran Hospital and Rehabilitation Center, 559 Capitol Boulevard, St. Paul, MN 55103

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS



12977-41107
Univ. of Pittsburgh
Falk Library of the Health
Profession
Pittsburgh, PA 15261-0001

THE CHANGING FACE OF
AIDS IN MINNESOTA

NOVEMBER 1995



WE CAN SAVE YOU BOTH.

Everyone agrees that it's important to stay current. But who can keep up in this day and age of explosive new information?

We discover the key meetings—so you don't have to. Audio-Digest saves you the time and expense of traveling to meetings. Every year, we exhaustively cover more than 350 major meetings, seminars and postgraduate courses in 13 specialties. Then, because a 1-hour talk may contain only 30 minutes of true substance, we painstakingly edit so that you hear only the “meat” of the presentation—in less time, with no loss of important content.

Perhaps best of all, you stay current on **YOUR OWN TIME**. You listen when **YOU** want—at home, in the office between patients, while you're driving, while you're exercising. It's up to you.

You think, “It can't be that easy.” We say it can.
For more information and a **FREE SAMPLE CASSETTE**,
call **1-800-423-2308** now. It will cost you nothing for the call.
AND IT COULD SAVE YOU A GREAT DEAL.



Audio-Digest Foundation®

All medical courses are planned and produced in accordance with the Accreditation Council for Continuing Medical Education (ACCME) Essentials. Program tapes are presented by Audio-Digest Foundation, a subsidiary of the California Medical Association. The California Medical Association is accredited by the ACCME to sponsor continuing medical education for physicians.

Each Audio-Digest program is approved for up to 2 hours of Category 1 credit, and may be applied toward the American Medical Association's Physician's Recognition Award and additional credit where designated by qualified boards and associations, including being acceptable for 96 hours annually of prescribed credit by the American Academy of Family Physicians.

NOV 15 1995

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Joseph
Daniel Fiedler.

DEPARTMENTS

- 5 EDITOR'S NOTEBOOK
- 67 NEWS CLIPS
- 71 MMA SPONSORS
- 73 CME IN MINNESOTA
- 75 CLASSIFIED ADS
- 80 INDEX TO ADVERTISERS

FACE TO FACE

- 6 MORE THAN MEDICINE: CARING FOR THE AIDS PATIENT** Katie Colón
HCMC physicians Margaret Simpson and Ron Schut provide a broad spectrum of AIDS patient care and research.

BOOK REVIEW

- 8 LIGHT IN THE HEART OF DARKNESS** Charles R. Meyer, M.D.
In "My Own Country," Abraham Verghese tells the riveting story of his thriving AIDS practice in a small Tennessee town and how his patients' disease began to consume his own life.

FEATURE STORY

- 10 ATTITUDE ADJUSTMENT: A COMPLACENT PUBLIC TUNES OUT THE AIDS EPIDEMIC** Miriam K. Feldman
Education and prevention remain our only weapons against AIDS, but a fatigued and complacent public is growing harder to reach.

CLINICAL & HEALTH AFFAIRS

- 15 HIV: AN ENDEMIC HEALTH PROBLEM IN MINNESOTA** Keith Henry, M.D.
- 17 MANAGEMENT OF HIV INFECTION: A 1995-96 OVERVIEW FOR THE CLINICIAN** Keith Henry, M.D.
- 26 DIRECTIONS IN HIV/AIDS RESEARCH: A MINNESOTA PERSPECTIVE**
Keith Henry, M.D., Holly Melroe, R.N., and Ray Nelson, R.N.
- 35 HIV INFECTION IN WOMEN AND CHILDREN** Kay E. Schwabke, M.D., M.P.H., and Laura G. Hoyt, M.D.
- 41 NEEDLESTICK/SHARPS INJURIES AND HIV EXPOSURE AMONG HEALTH CARE WORKERS: NATIONAL ESTIMATES BASED ON A SURVEY OF U.S. HOSPITALS** Keith Henry, M.D., and Scott Campbell, R.N., M.S.P.H.
- 45 U.S. PRISONERS' ACCESS TO EXPERIMENTAL HIV THERAPIES**
Abigail Collins, Dana Baumgartner, B.S.N., M.S.H.S.A., and Keith Henry, M.D.

SPECIAL REPORT

- 59 TWO FOR THE SHOW: EDI AND ELECTRONIC COMMERCE** Sue Chapin-Strike
EDI improves the efficiency and cuts the costs of countless health care-related business transactions. Second of three parts.

49 *The Monitor*

HIGHLIGHTS MMA Annual Meeting • House of Delegates' action on resolutions • Election of MMA officers • 1995 MMA Awards

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$40. Single copies—\$3.50. Canadian—\$70. Foreign—\$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1995-96 Officers

President
Michael J. Murray, M.D.
President-Elect
Raymond G. Christensen, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Paul R. Hamann, M.D.
Secretary
Judith F. Shank, M.D.
Treasurer
Erick Reeber, M.D.
Speaker of the House
Anthony C. Jaspers, M.D.
Vice Speaker of the House
Blanton Bessinger, M.D.
Past President
Andrew J. K. Smith, M.D.
Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.
N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.
N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.
West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.
East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.
S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.
S.E. District
Peter Amadio, M.D.
David C. Herman, M.D.
Noel R. Peterson, M.D.
Resident Member
Scott Stafford, M.D.
Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.
AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair
AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.
Chief Financial Officer
George C. Lohmer Jr.
Director of Legislation and Public Policy
David Renner
Director of Communications
Mark S. Vukelich

URGENT CARE OPPORTUNITIES

HealthPartners, Inc.

HealthPartners, Inc., is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24-hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according

to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, 1-800-472-4695, or send CV to:
HealthPartners, Inc., Physician Services,
Attn: Ann Mliner, 8100 34th Avenue South,
P.O. Box 1309, Minneapolis, MN 55440-1309.

An EO/AA Employer.



HealthPartners

HealthPartner's mission is to improve the health of our members and our community.

**At many hospitals,
physicians battle every day with
things invisible to the naked eye.**

At North Memorial, we think you should spend less time worrying about your career and more time worrying about your patients. That's why we believe in policies that are also beneficial to Internal Medicine and Family Practice Physicians. If you'd like to practice in a truly innovative medical community in Minneapolis or a surrounding suburb, call a Physician Placement Coordinator at 1-800-275-4790.

Such as hospital policies.

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, or you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

**To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)**

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

AIDS

Public Perceptions Obscure Medical Discourse

Charles R. Meyer, M.D.

AIDS is more than a disease. AIDS is more than an epidemic. In the 14 years since its first description, it has prompted debate and discussion out of proportion to the absolute numbers of affected individuals. Politics, prejudice, and publicity have warped what should have been primarily a medical discourse about combatting a new disease. This month's *Minnesota Medicine* considers the status of AIDS in 1995 with a feature article on public apathy and political backlash, a profile of two physicians on the front lines of caring for AIDS patients, and a compendium of AIDS-related scientific articles compiled and edited by Keith Henry, M.D., director of the HIV/AIDS Clinic and Programs at St. Paul-Ramsey Medical Center.

These articles describe basic research, clinical science, and clinical practice. Yet no discussion of AIDS is confined to etiology, diagnosis, and treatment. Why is that? Primarily because AIDS is a symbol, and, like most symbols, its significance extends beyond reality. Depending on the beholder, AIDS is a symbol of societal prejudices, of medical science's failures, of economic strain on the health care system worldwide, or of hidden corrosion in our society.

AIDS attained its symbolic status because it is an epidemic unique in medical history. Unlike bubonic plague, cholera, or polio, which killed indiscriminately, AIDS primarily strikes selected groups stigmatized for behavior condemned by some members of society. For many people with AIDS, getting the disease means not only life-limiting debility, but also social ostracism. Also unlike previous "plagues," in which diagnosis and symptomatic illness coincided, HIV infection is evidenced



"We need to sort through the politics and polemics of AIDS."

by a positive antibody that starts a grim timer set to an unknown hour. Before the alarm rings and illness arrives, the victim lives on death row awaiting the first infection.

The pathos of its victims has made AIDS a media montage. The strident advocacy of gay and lesbian groups has fired the political dialogue. The pictures need to be seen and the truth of the epidemic needs to be told, but the din has affected the reason of the debate. Elinor Burkitt in her book, "The Gravest Show on Earth," calls AIDS "the most politically controversial epidemic in human history." Although her book occasionally muckrakes, Burkitt tells dismaying stories of groups or individuals who have distorted a rational approach to AIDS—gay communities that did not listen to the early warnings about safer sex, researchers who were more concerned with PR than DNA, government officials who did not recognize an evolving epidemic.

As former New York City Health Commissioner Stephen Joseph said: "AIDS is one of those transcendent

phenomena. Everything that is America is in the epidemic, both the good things and the bad things. All the courageousness and cowardliness, all the tolerance and all the prejudiced bigotry, all the technological mastery and all the social stupidity. All the poles of everything that is our nation is in our epidemic."

AIDS has changed the practice of medicine, introducing universal precautions and accelerating FDA drug evaluations, for example. But many AIDS activists would say there has been little progress since 1981. They continue to press for more funding and earlier release of therapeutic agents. Yet research moves slowly and change in human behavior even more so. Lewis Thomas, speaking from the heart of the medical research establishment, wrote in 1991: "Considering that the virus has been recognized for less than a decade and that it is one of the most complex and baffling organisms on earth, the progress that has already been made in the laboratories working on it is an astonishment." Our articles reveal further scientific progress. Human behavior lags behind.

Many years ago, Minnesota epidemiologist Michael Osterholm said that medicine in the 20th century may be judged by how we respond to AIDS. Sobering as that is, we may yet be judged favorably if we approach AIDS with passion, compassion, and dispassion. We need to tap the passion of AIDS activists to continue fighting the epidemic. We need to give our compassion to those who suffer. And we need to be dispassionate doctors who can sort through the politics and the polemics and treat a disease and its victims with medical science's tools.

MM

More than Medicine

CARING FOR THE AIDS PATIENT



PHOTOGRAPH BY BRUCE BAIRD

HCMC PHYSICIANS MARGARET SIMPSON AND RON SCHUT PROVIDE A BROAD SPECTRUM OF AIDS PATIENT CARE AND RESEARCH, INCLUDING PSYCHOSOCIAL SUPPORT AND ACCESS TO EXPERIMENTAL DRUG TREATMENTS.

B Y K A T I E C O L Ó N

It was the spring of 1983. As Margaret Simpson, M.D., and her husband boarded their flight from San Francisco back to Minneapolis, a young man on the plane caught Simpson's eye. Seated in a wheelchair, he had some noticeable skin lesions and looked as though he had lost a good deal of weight—his belt cinched tight to hold up his pants. Simpson leaned over and

nudged her husband, also a physician. "I wonder if this man has leukemia or maybe AIDS," she said.

Although she had never had a patient with AIDS, Simpson knew enough about the new disease to recognize the man's lesions as possibly symptomatic of AIDS. Two days later, as she arrived for work at Hennepin County Medical Center, one of the residents approached her with the sobering news. "We have our first AIDS patient," he told her. Walking into the patient's room, Simpson came face to face with the young man from the plane—home on a visit to his family.

Today, 12 years after that first AIDS patient arrived at HCMC, Simpson and colleague, Ron Schut, M.D., oversee the care of 500 to 600 patients annually through the hospital's HIV/AIDS Program.

Over the years, not only have the numbers changed—growing from an average of 50 clinic visits per quarter in 1985, to a current average of 700 per quarter—but there has also been an evolution in patient care, societal attitudes, and in the patient population itself. Like the young man on the plane, those who came to the hospital during the early years were "very sick people," with full-blown AIDS, Simpson says. With the advent of a blood test for detecting HIV in 1985, the clinic also began seeing people who were not yet ill but who might be at risk. The number of patients in the program grew steadily as treatments went from solely reactive, with drug therapy for symptomatic people, to proactive, with preventive treatments for HIV-positive patients who were still symptom-free.

As director of the HIV/AIDS Program at HCMC for the last 10 years, Simpson says her objective has been to present a spectrum of appropriate AIDS patient care and research, including psychosocial support for those patients who need it.

A native of McCloud, California, Simpson graduated from medical school in West Virginia in 1976 and did her research fellowship in infectious disease at the University of Minnesota. Throughout her medical training, Simpson says she fully anticipated that her career would involve working with *curable* diseases. "If you had told me then that I would be dealing with a mortal, sexually transmitted disease someday, I never would have believed it," says Simpson. But AIDS changed the path of her career.

In addition to being the AIDS program director at HCMC, Simpson currently serves as the hospital's infection control chair and principal investigator for case man-

agement. "Working with HIV and AIDS has taught me a lot," she says, adding that she is committed to being involved in AIDS and patient care for as long as the disease endures. She sees her role slowly shifting toward more direct patient care, with less focus on administrative functions.

As both administrator and the only full-time physician in the program for many years, Simpson faced growing stresses and demands as patient volume steadily increased. Much of that stress was alleviated with the



"WE WANT TO PROVIDE OUR
PATIENTS WITH COMPARABLE
ACCESS TO ALL NEWER
AGENTS—THE SAME ACCESS
AS ANYONE ELSE IN THE
COUNTRY MIGHT HAVE."



SIMPSON & SCHUT continued on page 62

LIGHT *in the* HEART *of* DARKNESS

BY CHARLES MEYER, M.D.

I have a confession to make. I don't like reading about AIDS, partly because I see few HIV patients in my daily practice, and also because its unrelenting tragedy is exhausting. So why did I like this book? It is an engaging view of an intriguing doctor, a striking epidemiological microcosm, and a compilation of many riveting personal HIV stories.

Abraham Verghese is not your average medical subspecialist. The son of Christian Indian parents, Verghese was raised and educated in Ethiopia and came to an infectious disease practice in Johnson

J_N "MY OWN COUNTRY" (SIMON & SCHUSTER, 1994) ABRAHAM VERGHESE TELLS THE RIVETING STORY OF HIS THRIVING AIDS PRACTICE IN A SMALL TENNESSEE TOWN AND HOW HIS PATIENTS' DISEASE BEGAN TO CONSUME HIS OWN LIFE.

City, Tennessee, via residencies in Tennessee and Boston. He also is a graduate of the Iowa Writers' Workshop who writes fluid prose and revealing dialogue. "My Own Country" shows how the objective practitioner became a consumed caregiver as his HIV patient population grew in the unlikely venue of Johnson City. Like mycobacterial consumption, his HIV-dominated practice eventually threatened his physical and marital health.

Verghese' struggle to balance involvement and objectivity feels uncomfortably familiar to any practitioner who has treated patients whose demise is inevitable. He laments: "getting so close to [patients] that I would regret it later, knowing that the intimacy made the ordeal of illness costly and painful to me." His ambivalence about associating with "marked" patients should feel uncomfortable to all readers. Although opposed to the social ostracism of AIDS, he still felt stigma by association. "I was ... tainted socially by the association with my patients, even if most days I told myself I cared nothing about what others thought."

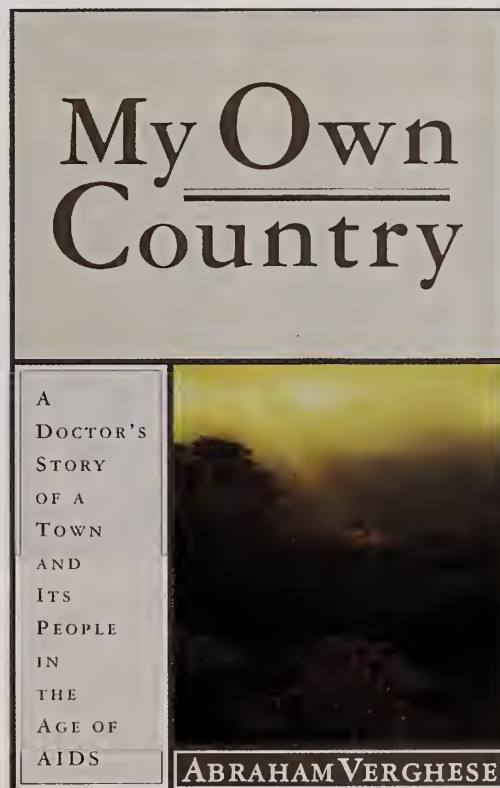
The site of this drama was Johnson City, Tennessee, a southern city that the author describes as moving

from redneck and ignorant to gentrification, but nonetheless, a city of the South. Vergheese was drawn to those loyal and trusting people who would "give you the shirt off their back" and "trust a stranger to the point of stupidity." This world of pickup trucks and America-first seems an unlikely spot for an infectious disease specialist to become inundated with AIDS patients. Yet his HIV-positive practice mushroomed. Gay and bisexual, male and female, his patient cohort reflected the broadening spectrum of HIV.

Beyond the epidemiology are the stories. Gay couples ministering to each other until death. An HIV-infected wife struggling with her husband's infidelity. Vergheese mines these tales not only in the exam room and hospital, but also in gay bars and patients' trailer homes. Through sometimes lengthy dialogue, he explores what it means to be gay, what it feels like to be terminally ill, and what AIDS should be telling us as a country.

Vergheese had to leave Johnson City to save his marriage and, perhaps, his soul. He describes his road trip across country to a new life. The lightness of a burden lifted is mixed with the loss of a life at the intense center: "But it is also hard to pull away from the extreme, from life lived far from mundane conversation. Never before AIDS and Johnson City have I felt so close to love and pain, so connected to other people." After all the tragedy and trials, all the wasting humans and wasted lives, it is this connection that he leaves us with. His last line in the book is: "I remember the acts of human kindness that illumine our world." This book will illumine yours. **MM**

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.



ATTITUDE ADJUSTMENT

A Complacent Public
Tunes Out the AIDS Epidemic

When Legionnaires' disease broke out in Luverne, Minnesota, this summer, it was big news, and part of the story was a victim's account of his brush with death. In one televised report, a man interviewed from his hospital bed tried to sound philosophical about his fate. Contracting the disease was just a matter of bad luck, he told a reporter. Anyone can get Legionnaires' disease, tuberculosis, AIDS—anywhere, anytime, he said.

Lorraine Teel, executive director of the Minnesota AIDS Project (MAP), watched that news report in horror. If she could have, she would have told the man exactly what she and other MAP educators have been trying to get across to the public for years. She would have explained how people become infected with AIDS. "You can breathe from an air conditioner and get Legionnaires' disease," she says. "But unless you're engaging in unsafe sex or injecting drugs with someone (who's infected), you're not going to get AIDS."

Education
and preven-
tion remain
our only
weapons
against
AIDS, but a
fatigued and
complacent
public is
growing
harder to
reach.

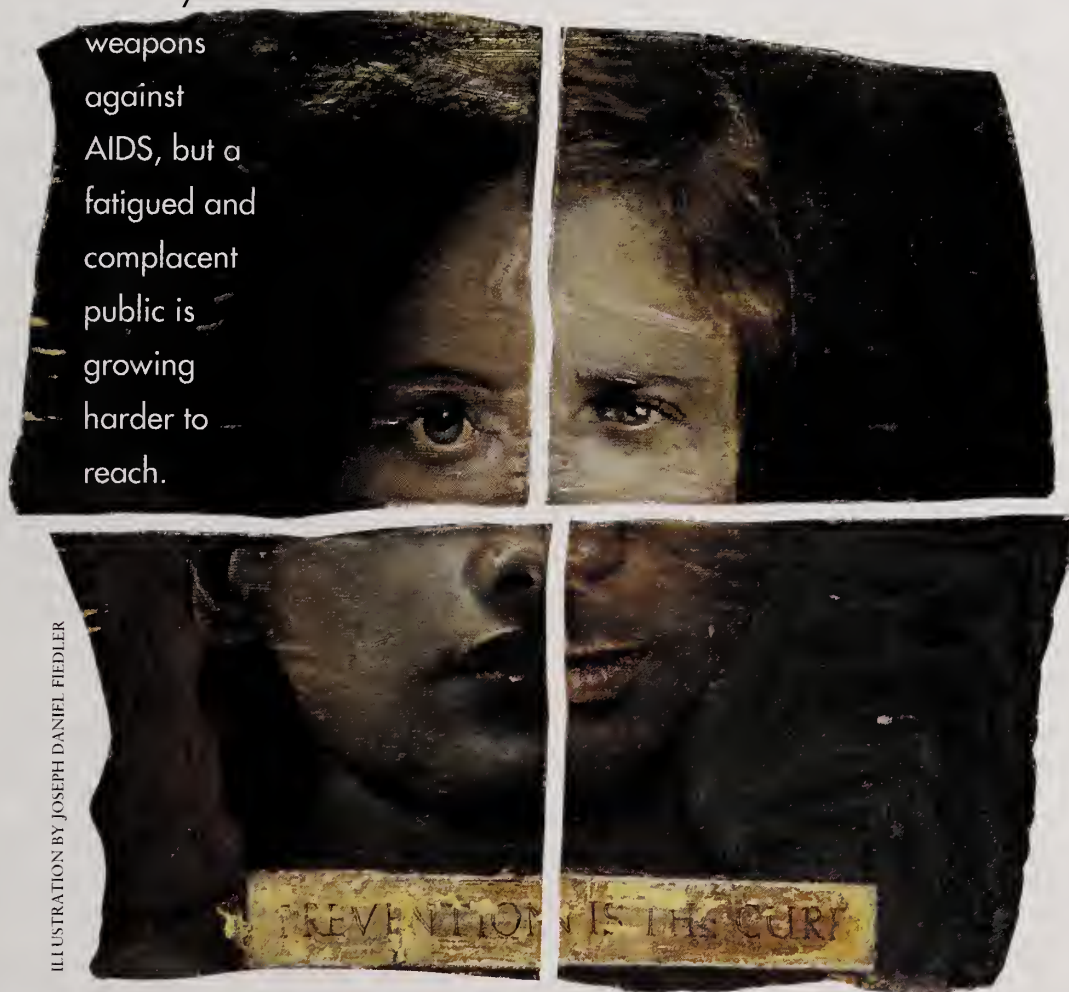


ILLUSTRATION BY JOSEPH DANIEL FIEDLER

BY . . .
MIRIAM K.
FELDMAN

Fifteen years into the epidemic, and there's still an extraordinary amount of ignorance and misinformation about the virus, which is the No. 1 killer in the United States of men and women between the ages of 25 and 44. As of August 1, more than 2,500 cases of AIDS have been reported in Minnesota, and 1,550 people have died from the disease. While about 2,200 non-AIDS HIV cases have been reported, estimates of the actual number of cases range as high as 17,000. The numbers aren't going down, either. Each year, about 40,000 to 60,000 people continue to be infected nationwide.

Education—The Only Defense

After all these years, there's only one line of defense against AIDS, and that's education. "Education. Education. Education. It's the only thing that's going to end AIDS," says Scott Strickland, M.D., of the Department of Infectious Disease at Park Nicollet Clinic-Health System Minnesota. "We don't have vaccines or treatment. Education is the only thing that works."

Educating the public isn't easy, though, as demonstrated by the story about the man who believes AIDS is as contagious as an airborne disease. "The message has been out there for 15 years, and we're not there yet," notes Bob Tracy, MAP's director of public policy. "You even have politicians raising doubts in the community with questions like, 'Does HIV really cause AIDS?'"

A Changing Attitude

For a while at least, AIDS educators believed they were making some progress toward teaching the public about how the virus is and isn't transmitted, and how people living with AIDS should and shouldn't be treated. But people who work with AIDS sense a shift in public attitude and mood. "Fifteen years into the epidemic and I think we are in some ways on the beginning of a downward spin in terms of the issue of HIV and AIDS," Teel says.

That downward spin is the result of numerous factors, ranging from an inability to talk about the issues associated with AIDS—namely, sex, drugs, and death—to the new, conservative political mood that seeks to silence the very conversation that needs to take place. "Just say no" messages aren't enough when it comes to AIDS, experts say.

Other factors have confounded efforts to educate the public about AIDS. Older gay men, who once organized highly effective public health campaigns, are worn out by the psychic and physical toll of the disease. Younger gay men think HIV is an older people's disease and believe they'll be safe if they stick to having sex with people their

own age. Women have a tendency to think HIV is not their problem. Minority communities think HIV is a white problem. And some people would prefer to treat AIDS like it's not really a problem at all.

For one reason or another, people are tired of AIDS. "Been there, done it, seen it, and we don't want to be there, do it, see it again." That, says Teel, sums up the mood of the country when it comes to AIDS. "I think with the new Congress and the new mood in the country, we're tired of seeing this, we're tired of the homosexual lobby. We want to move on to other things. And we're done with this."

This attitude has serious public health implications, according to Strickland, who has been caring for patients with HIV and AIDS since 1982. "People who've previously been educated about HIV are becoming fatigued," he says. "They're not always following protocols as much as they used to. ... We're just going to go back to 1982 again. People are not taking precautions as they should. It's terrifying to think what's going on."

The prevailing ennui is sparking a dangerous trend in which the public appears to be letting down its guard when it comes to AIDS. Russ King, MAP's director of communications, puts it this way: "There's a loss of that initial fear we all had. The epidemic mentality is gone from our society."

But AIDS is still very much an epidemic, and it knows no boundaries. Heterosexual transmission of HIV increased 130 percent from 1992 to 1993. And women are accounting for more and more AIDS cases: 18 percent in 1994, compared with 7 percent near the start of the epidemic.

Prevention Is the Cure

Jill DeBoer, the section manager for AIDS/STD Prevention Services at the Minnesota Department of Health, knows how hard it is to deliver effective public health messages today. "I think people are becoming complacent," she says. "HIV is becoming part of our societal picture. For many people, it's not seen as an epidemic anymore. That makes it more challenging to get people to become interested."

DeBoer's section tries to figure out ways to get people to change their behaviors. "Our most challenging problem is coming up with innovative prevention ideas," she says. Her office has been refining AIDS messages and has found it helpful to target them to specific groups, such as African-American and Asian-American gay men, for example. DeBoer notes that it takes time to develop the right approach, just as it took years to develop effective smoking-prevention programs. "HIV is still in its infancy

Minnesota AIDS Project ... *the voice of an epidemic*

Describing the Minnesota AIDS Project (MAP) is a bit like trying to pin down an octopus. There are so many arms, it's hard to tell which one to get to first. In fact, MAP describes itself as having three arms: service, education, and advocacy. Not as many as that eight-armed creature, but MAP does reach far and wide into the Twin Cities community, as well as throughout the state.

Since 1983, MAP has been reaching out to achieve its mission, which is to reduce the impact of HIV and AIDS in Minnesota. Founded in Minneapolis at the start of the AIDS epidemic by a small group of volunteers, MAP has grown to a staff of more than 50, with offices in Duluth, Rochester, and St. Cloud.

The numbers alone suggest MAP has been highly successful. Last year it provided a variety of services, including:

- direct services, such as case management, housing, legal services, buddies, and transportation, to some 2,500 persons living with AIDS;
- outreach and education to more than half a million individuals. Contacts are made on the AIDSLine, a telephone hotline, as well as a street outreach to at-risk populations, and through speakers at schools, businesses, churches, and civic organizations;
- distribution of more than 350,000 pieces of literature and 256,000 condoms and bleach kits for cleaning syringes.

Yet numbers don't begin to tell the story of MAP. Russ King, MAP's director of communications, suggests that one anecdote is like the proverbial picture, able to amplify better than all the statistics combined. To illustrate how MAP works, King tells the story of a young man on the brink of a serious illness who had never put his legal affairs in order. Knowing that, MAP arranged to have one of its 50 volunteer attorneys visit the man in the hospital to draft a living will and a health care power of attorney document. This kind of response to persons living with AIDS is all in a day's work

for MAP, according to King. "It shows we will go where people need us," he says.

MAP, in fact, relies on more than 1,200 volunteers, not just attorneys, to do what's needed, which is everything from stuffing envelopes, to providing transportation, to taking an AIDS buddy to a movie.

In addition to its role as community educator and attendant to the day-to-day needs of the seriously ill, MAP regards itself as an advocate for those affected by HIV and AIDS by working to influence public policy. Last year, for example, MAP was influential in halting a bill in the Minnesota Legislature that would have made it a crime to transmit HIV. MAP also fought successfully for fair and equitable distribution of federal funds, and it began Positive Link, a telephone counseling program for individuals newly diagnosed with HIV or AIDS.

As Lorraine Teel, MAP's executive director, puts it, MAP gives expression to the needs of persons with HIV and AIDS. "Unless we are out there as a loud voice," she says, "people will not have a voice." —MKF

The Minnesota AIDS Project offers a telephone hotline service that provides information, resources, and emotional support. The anonymous information and referral line serves people living with HIV and AIDS, as well as family members, caregivers, friends, and health care professionals. The telephone service provides, for example, information on HIV testing sites and safer-sex techniques. MAP also offers "Positive Link," an anonymous phone service that provides peer support to individuals newly diagnosed with HIV or AIDS by linking them to volunteers who also are living with the disease. Both hotlines can be reached by calling 612/373-AIDS or 800/248-AIDS.



"99 to 1 Chance. I Took It"



Acutely ill, medically complex patients are our specialty. That's why Mr. Corey was transferred from an acute care hospital to the THC network of extended critical care hospitals. We're committed to a cost effective continuum of care for patients suffering from catastrophic illnesses or acute level chronic diseases. Aggressive therapies and outcomes-oriented programs return each patient to the most productive life possible. Just ask Mr. Corey. Given little chance of recovery, he wanted the most out of life. And he got it. A "99 to 1 chance. I took it and am getting well."



612-588-2750

Medically Complex Program • Pulmonary/Ventilator Program
Wound Care Program • Low Tolerance Rehabilitation Services

in terms of strategy," she says. "Most agencies are struggling with what is effective."

It hasn't helped that from the start AIDS has been caught up in various political, moral, and personal agendas. "To me, the story is the continuing politicizing of AIDS," Teel says. It's hard to do effective public health education when the disease is seen as political, she explains. "If TB were political, you'd have a serious epidemic."

Yet groups like MAP and the Department of Health continue to work at getting the message out, and whatever the message, it has to be repeated, over and over. "It's a lifetime of messages," Teel says. "It's just like the seat belt message, or heart disease. It's not one time." What's more, she says, "the message has to come from every quarter," not just MAP and the Health Department. It has to come from billboards, churches, synagogues, and schools. "It has to be the cumulative weight that eventually causes people to change their behavior."

Teel acknowledges that talking about AIDS isn't as easy as talking about seat belts. As she puts it, conversation about AIDS necessarily involves three things people are most reluctant to discuss: sex, drugs, and death. "Every time you talk about AIDS, it brings up those issues on a very personal, intimate level to everybody who's involved in the conversation. And until you get over the hurdles of human sexuality, human drug use, and the process of dying, and all of what that means, you can't deal with AIDS."

AIDS continued on page 64

HIV: An Endemic Health Problem in Minnesota

Keith Henry, M.D.

I remember very clearly the first reports about a new clinical syndrome that surfaced in 1981.^{1,2} I recall thinking at the time, "If this is an infectious disease spread by sexual contact and blood exposure, then we are facing a nightmare." Well, events have demonstrated that the human immunodeficiency virus (HIV), the causative agent of AIDS (acquired immunodeficiency syndrome), is spread almost entirely by exposure to sexual secretions and blood. Fortunately, little has changed as far as the means of HIV transmission. Unfortunately, the HIV/AIDS epidemic has evolved to a degree almost unimaginable 15 years ago. Within Minnesota, over 2,500 AIDS cases have been reported, with more than 1,500 deaths, plus an additional 2,200 patients reported with non-AIDS HIV.

The AIDS epidemic is quite simply a disaster for humankind. The epidemic was put into a historic context several years ago by Donald Francis.³ A comparison of the mortality rates of HIV with other human viruses underscored its deadly nature. Francis predicted that AIDS would cause more deaths in the United States than the total of all the combat deaths from all U.S. wars combined. Sadly, his estimate of the mortality rate of HIV (>75%) may have been low (more likely pushing 90% to 100%) and his tally of AIDS deaths in the United States by 2010 appears conservative (750,000). As of November 1995, almost 500,000 AIDS cases have been reported in the United States, with nearly 300,000

deaths. Our nation will likely see a minimum of 25,000 deaths per year from AIDS over the next 15 years, yielding a staggering total of deaths by the year 2010.

The HIV/AIDS epidemic has had a profound impact on society, the clinical community, and on biomedical research. Within the United States, the gay and intravenous-drug-abusing communities were initially most affected. Trends over the last several years indicate that HIV/AIDS increasingly is becoming concentrated in women and the African-American and Hispanic communities. Nearly 75% of women with AIDS and 80% of children with AIDS belong to these communities of color. Given the increasingly fragile state of medical care and social support for these populations, such trends should be viewed with alarm. In Minnesota, as well as the nation, HIV/AIDS has become an endemic clinical problem of an immense magnitude.

No longer increasing exponentially, the HIV infection rate appears to have achieved a balance where approximately the same number of persons are dying each year as are becoming infected. Unfortunately, data do not suggest that efforts to educate the public on how to prevent HIV infection are having enough impact to slow the rate of new infections. It appears that the threat of HIV will be with us for decades to come.

On a more positive note, the AIDS epidemic has led to many health care innovations and improved treat-

ments. For one, it has stimulated great interest in the diagnosis and treatment of viral infections. Who had even heard of T-helper cells or retroviruses in 1981? The treatment of AIDS-related opportunistic infections has direct applicability to numerous other patient populations, for example, transplant and cancer patients. The success of AIDS activists has boosted the concept of patient involvement in setting a research agenda and in making clinical decisions. The AIDS crisis has markedly increased the pace of FDA approval of new drugs. The challenges of caring for persons with HIV/AIDS has stimulated the development of multidisciplinary care teams, outpatient clinics, home care, foster care settings, and hospice care.

With the growing number of treatments comes greater complexity. Care for some patients with advanced HIV disease, often based at home, is so complicated that I often have used the term "outpatient intensive care" to describe it. The standards of HIV care continue to move so rapidly that textbooks and review articles are frequently outdated by the time they are published. The care of patients with HIV infection, though often frustrating, is extremely stimulating and often very rewarding.

The compilation of articles in this special section of *Minnesota Medicine* provides an overview of a spectrum of HIV-related issues. The broad topics of clinical management of HIV infection and the state of HIV research in Minnesota are discussed in

review articles that update information last discussed in *Minnesota Medicine* in November 1993. Special populations are discussed in the other three articles: HIV in women and children (page 35), HIV risks in health care workers (page 41), and HIV in prisoners (page 45). These articles highlight some of the features of the HIV epidemic that make it a unique health problem: the concentration of cases in certain populations, its linkages with poverty, and the fear and real risk of contagion among caregivers.

Overall, Minnesota has responded well to the HIV epidemic. Access to health care is excellent by national standards. Numerous clinical sites have HIV expertise throughout the state. Minnesota makes important contributions to HIV research, led by efforts based at the University of Minnesota (for information about

available studies, call 612/221-1280). The Minnesota Department of Health has spearheaded the public health response; the effort includes a continued focus on controlling sexually transmitted diseases, which helps reduce HIV risks as well.^{4,5} The Department of Human Services and other state agencies continue to facilitate the development of services for HIV-infected persons through Ryan White Care funding and other mechanisms. Many community-based agencies provide key education, social support, and mental health services. Unfortunately, this generally effective care system is quite fragile and will likely face significant funding cuts over the next several years because of current political upheavals and stresses on tax-supported systems.

The goal of this HIV-focused issue of *Minnesota Medicine* is to

increase awareness about many of these issues among physicians throughout the state. Despite the continuous changes occurring in health care delivery, I hope that the HIV care, service, and research infrastructure can somehow be protected and improved in the midst of so many changes. Physicians can influence the direction that schools, medical care systems, and government will take in health and AIDS education, and I urge physician involvement to help minimize the impact of HIV in the future. In most need of our attention are the provision of HIV prevention education and the delivery of health care to the communities of color. Our approach to the challenges of HIV from a clinical and societal perspective will reflect our priorities in Minnesota. I am confident that Minnesota physicians can continue to make a difference in the management of this endemic problem.

MM

K eith Henry, M.D., who compiled the following Clinical & Health Affairs series on HIV and AIDS, is a nationally renowned clinical HIV/AIDS researcher. He has been director of the HIV/AIDS Clinic and Programs at HealthPartners St. Paul-Ramsey Medical Center since 1985 and medical director of the HIV Unit and the Sexually Transmitted Disease Clinic, St. Paul Department of Public Health, since 1986. In addition, he is an associate professor at the University of Minnesota Medical School and is involved with



the AIDS Clinical Trials Group sponsored by the National Institute of Allergy and Infectious Diseases. Together with colleagues at Hennepin County Medical Center and Park Nicollet Clinic, he recently helped form the AIDS Research Consortium of the Twin Cities (ARCTiC). The consortium, which he directs, seeks out companies working on promising new AIDS drugs and submits proposals to serve as trial sites, the goal of which is to offer patients quicker access to experimental therapies.

REFERENCES

1. Centers for Disease Control and Prevention. Pneumocystis pneumonia—Los Angeles. MMWR 1981; 30:150-2.
2. Centers for Disease Control and Prevention. Kaposi's sarcoma and Pneumocystis pneumonia among homosexual men—New York City and California. MMWR 1981;30:305-8.
3. Francis DP. Toward a comprehensive HIV prevention program for the CDC and the nation. JAMA 1992; 268:1444-7.
4. Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomized controlled trial. Lancet 1995;346: 530-6.
5. Laga M. STD control for HIV prevention—it works! [Editorial]. Lancet 1995; 346:518.

Management of HIV Infection

A 1995-96 Overview for the Clinician

Keith Henry, M.D.

ABSTRACT

Although the challenges of HIV/AIDS care may seem overwhelming, we are better able than ever to positively affect the course of HIV for each individual patient.

Treatment goals involve three areas:

- 1) Antiretroviral drugs aimed at retarding the rate of HIV replication, thus reducing the rate of damage to the immune system;
- 2) drugs used to treat or prevent opportunistic infections seen in the context of HIV-related immune deficiency; and
- 3) drugs used to treat symptoms or syndromes commonly seen in these patients (including dementia and wasting syndrome). The multitude of clinical problems seen in advanced HIV disease leads to significant polypharmacy and costs resulting in a very complex and confusing situation. I recommend that physicians with little HIV experience link up with an HIV specialist when caring for HIV-infected patients to optimize access to the best therapies or research studies currently available. With no cure in sight, physicians need to focus on educating the public and patients about how to avoid HIV infection and to identify persons who are infected to minimize spread.

From the beginning, treatment of HIV infection/AIDS has posed many challenges to clinicians. In the early years of the epidemic, few therapies were available, and patients with AIDS often had a very short survival. Over the last decade, much has been learned about the natural history of HIV/AIDS, and many treatments have been developed. Unfortunately, we are a long way from a cure, and the plethora of therapies available adds up to almost overwhelming polypharmacy with attendant high costs, poor compliance, and drug-related adverse events. Our perceptions about the benefits of HIV therapy have been on a roller coaster ride, now settling into a period of realism.

Unlike most other major diseases (such as heart disease and cancer), AIDS puts patients at permanent risk for a wide range of life-threatening complications spanning the spectrum from infections (bacterial, viral, parasitic, and fungal) to cancers and wasting. Efforts to prevent and treat many of these complications have made headway, but each treatment contributes only modestly to any survival benefit and is relatively independent of other treatments; thus, patients often experience a sequence of complications, each adding to their disease and treatment burden, until they reach a point when their illnesses are uncontrollable. When patients reach that point, their needs focus more on symptom relief and emotional support. This discouraging situation underscores the importance of further studies to help us understand the potential of current and newer therapies to improve outcomes.

The care of HIV/AIDS patients is rewarding but frustrating. In many cases, the best therapy option is not clear. With the availability of superb

patient-focused newsletters and electronic bulletin boards, patients often know as much about the treatments as the physician (see Table 9, page 33, in the accompanying article on HIV research). The field of HIV/AIDS, nonexistent 15 years ago, now has entire books devoted to the subject.¹ In this article, I highlight important aspects of current HIV therapeutics, often offering my opinion as to the best therapy.

SURVIVAL IN AIDS PATIENTS

The clearest therapeutic goal in HIV/AIDS care is to lengthen survival significantly. Unfortunately, even that objective is steeped in controversy. Current dogma suggests that a typical time period from initial HIV infection to the development of clinical AIDS (1987 CDC definition) is 10 years, with survival after that averaging one to two years. Although I believe that current therapeutics, begun reasonably early by an experienced clinician, can typically increase survival by several years, this is difficult to prove based on existing data.

It is worth reviewing the first AZT (zidovudine) study to better grasp this issue.² In that placebo-controlled study involving patients with AIDS or ARC (AIDS-related complex), 19 deaths occurred in the placebo group at three months versus one death in the AZT group, so the Data Safety Monitoring Board halted the study. The FDA quickly approved AZT and made it available at a time when no other therapy was available. Most of the deaths in the placebo arm were due to *Pneumocystis carinii* pneumonia (PCP), which is often preventable by prophylaxis (not allowed in that study). Thus, if the study were conducted today, it likely would not show a clear advantage of AZT therapy because a concurrent

Table 1

AIDS cause of death in 108 SPRMC patients (1984-94)

Non-specific AIDS progression* 40

AIDS wasting† 20

Unknown—not HIV related 8

Pneumocystis carinii infection 8

Cardiac 6

Non-Hodgkin lymphoma 6

Kaposi sarcoma 6

Progressive multi-focal
leukoencephalopathy 5

Other cancer 4

Aspergillosis 2

Pseudomonas sepsis 1*Mycobacterium-avium*
intracellulare 1

Cytomegalovirus 1

*no untreated treatable conditions

†1987 CDC AIDS definition

Table 2

What is known about antiretroviral therapy

Use of AZT once patient has advanced disease provides modest clinical benefit;

Use of AZT in asymptomatic patients delays development of AIDS (6+ months) but offers no survival advantage;

Patients with advanced disease (CD4<300) who switch from AZT to ddI after at least four months show a modest clinical benefit;

The combination(s) of AZT + ddI or ddC or 3TC result in improved clinical outcome compared with AZT monotherapy in patients with moderate disease (CD4=200-500)

DDI and ddC are roughly comparable for AIDS patients who can't tolerate or progressed on AZT, but overall they are not impressive;

Adding ddC to the treatment of patients with advanced disease who are AZT experienced adds little clinical benefit overall;

3TC and D4T appear well tolerated;

Many available 2- and 3-drug combinations suppress HIV RNA levels more completely than AZT monotherapy, but little clinical data are available yet;

Resistance is a major problem;

Cost and toxicity are major problems;

Better prevention/treatment of OIs further confounds clinical study endpoints; and

Adding acyclovir to AZT in advanced disease probably adds to survival advantage.

therapy would prevent the PCP.

The issue is further complicated by debate over the best time to start antiretroviral therapy (ARV). My interpretation of the available data (see discussion below) is that use of AZT monotherapy prior to AIDS delays progression to AIDS but does not significantly affect survival, since the period of survival with AIDS is shortened (because the diagnosis is made at a more advanced state of immune suppression).

Several studies suggest, in the modern treatment era, that survival with AIDS has lengthened from perhaps an average of eight months to 18 to 24 months. The definition of AIDS has changed several times (now including a CD4+ cell count <200/mm³ in an HIV-seropositive

person), making comparisons over time more difficult. Efforts to further lengthen survival must be based on an understanding of what conditions cause death in AIDS patients.

A review of the clinical course through death of 108 consecutive AIDS patients cared for at St. Paul-Ramsey Medical Center showed that the patients experienced an average of 3.5 AIDS-defining conditions prior to the point when they were no longer aggressively treated. Table 1 summarizes the causes of death for those patients, determined by a chart and clinical review. The review revealed that nonspecific AIDS progression was the major cause of death (defined as death occurring despite workup and treatment of all treatable conditions), with AIDS demen-

tia and wasting also top categories. It will not be possible to greatly improve survival unless treatments are developed that better shut down HIV replication and/or regenerate immune function, which would presumably decrease the risk of secondary complications. That is why most HIV/AIDS research is aimed at developing better ARV or immune-based therapies, rather than simply treating the complications once they have occurred.

ANTIRETROVIRAL THERAPY

New insights into the kinetics of HIV replication (discussed in the accompanying article on HIV research, page 26), and the attendant adverse effects on immune function highlight how formidable is the goal of shutting

down HIV growth long term. Even the hypothesis that more effective inhibition of HIV replication will result in significantly better clinical outcome is still unproven. The design of clinical studies has not kept up with the rate of change in knowledge about HIV and the availability of new technologies to quantitate HIV in the blood. Most completed or active large studies have utilized a fixed treatment strategy of one or two ARV drugs with a clinical or CD4 (T-helper cell) count endpoint.³ These studies could be viewed as seriously handicapped because resistance to the ARV drugs is predictable, so the therapies have a finite period of benefit. More recent Phase I/II studies have involved more aggressive use of ARV drugs, including comparing three-drug regimens with two-drug regimens. In general, the three-drug regimens have a modestly superior anti-HIV effect, but understanding the clinical benefit will have to await the results of Phase III clinical studies. These newer studies, though providing cause for hope, have not been clinically validated. Table 2 summarizes my view of what we know about ARV therapy, and Table 3 highlights key aspects of the five available ARV drugs.

ZIDOVUDINE (AZT) MONOTHERAPY

Much of the debate about ARV therapy has focused on the potential benefits of early AZT use. The basic problem is that all of the major studies have looked at AZT use long term, yet we now know that the HIV isolates from patients treated with AZT generally mutate and develop resistance to AZT treatment. A recent meta-analysis of studies of early use (a misnomer, since the HIV infection is often quite advanced) concluded that use of AZT pre-AIDS has a modest beneficial effect.⁴ The beneficial period of AZT monotherapy is variable, roughly based on the degree of immunosuppression (longer benefit with higher CD4+ cell levels), although generally there is at least a six-month period of benefit.

Since most of the available recommendations for treating HIV focus on AZT monotherapy and CD4+

cell counts, they are markedly outdated; essentially no one now believes that long-term AZT monotherapy is of major benefit. Preliminary results from the study ACTG 175 suggest that use of didanosine (ddI) or combination therapy is superior to AZT monotherapy, which likely will further reduce use of AZT monotherapy. One clear benefit of AZT monotherapy, however, is a decrease in the rate of HIV transmission from mother-to-neonate^{5,6,7} (see accompanying article, page 35).

COMBINATION THERAPY

In other infectious diseases (for ex-

ample, tuberculosis), combining drugs helps circumvent resistance when it's a problem. HIV has demonstrated a remarkable ability to mutate and become resistant to essentially every one of the hundreds of ARV drugs developed.^{8,9} Thus, it is theoretically attractive to employ strategies using multiple ARV drugs to delay the development of resistance and better suppress HIV replication. However, studies conducted to date do not convincingly demonstrate that adding a second drug delays the emergence of resistance. Several recently completed large Phase III clinical studies (ACTG 175 and

Table 3

Overview of currently available antiretroviral drugs

Retrovir (AZT, zidovudine)	Standard dose 2 (100mg) capsules TID. The most-studied ARV agent. Best time to initiate therapy not clear. A component of many combination therapy regimens. Proven benefit in decreasing maternal-fetal transmission. Perhaps 10% of patients cannot tolerate. Major toxicities are hematologic, myopathy, and GI.
Videx (ddI, didanosine)	Standard dose 2 (100mg) tablets BID. Most often used after AZT therapy, added to AZT, or as monotherapy. Least well tolerated of available agents (GI intolerance due to antacids, which are needed to maximize absorption). Major toxicities are peripheral neuropathy, diarrhea, and pancreatitis. Resistance may be less of a problem than with AZT.
HIVID (ddC, zalcitabine)	Standard dose 1 tablet (0.75 mg) TID. Probably equivalent to ddI in patients with advanced disease who have progressed while on AZT or were intolerant to AZT. Small tablet is easy to take and is better tolerated than ddI. Often used in combination regimens. Besides the toxicities associated with ddI, ddC is associated with pharyngeal ulcers.
Zerit (D4T, stavudine)	Standard dose 1 tablet (40mg) BID. Easy and convenient to take. Little clinical data available, but patients often do better switching to D4T than remaining on AZT. Less data available than with ddC and ddI, but I believe that it is equivalent or superior to AZT, ddI, or ddC as monotherapy. Very little data available on use in combinations. Preliminary data suggest slow development of resistance. Toxicities similar to ddI and ddC but less frequent.
3TC (lamivudine)	Standard dose 1 tablet (150mg) BID. Currently available through a compassionate-use protocol. Unimpressive as monotherapy but combined with AZT appears to have a prolonged anti-HIV effect when the 184 codon site mutation predictably occurs. The combination of AZT and 3TC appears to have a superior virologic effect out to one year than currently available combinations, but clinical data are lacking. Convenient dosing and well tolerated.

A consumer's guide to fighting HIV

The Centers for Disease Control and Prevention publishes guidelines for when and how to initiate anti-HIV therapies. Most physicians, however, offer individualized therapies for each patient. The diagram below represents a range of options and common practices currently available.

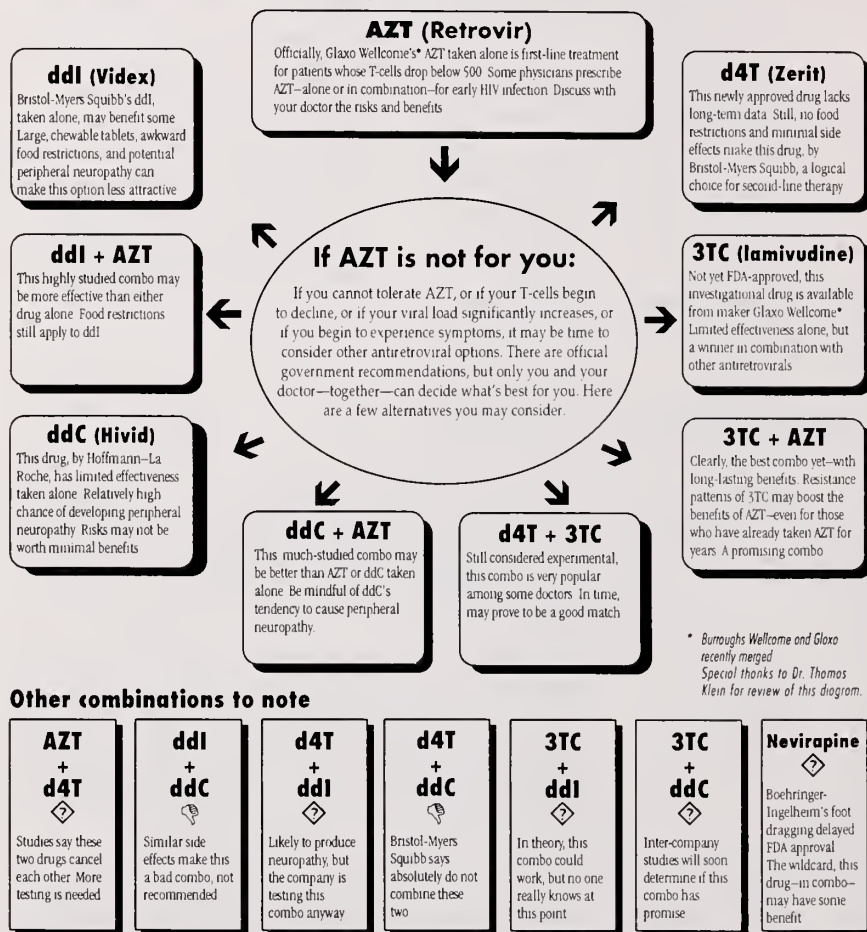


Figure 1—Treatment options. Reprinted with permission from Positively Aware, May/June 1995. ©1995 Test Positive Aware Network.

the Delta Study) have demonstrated that combination therapy with AZT + ddi or ddC offers clinical advantage compared with AZT monotherapy in patients with moderately advanced disease who were either AZT-experienced or naive. DDI monotherapy was also superior to AZT monotherapy (ACTG 175). These results are likely to alter treatment recommendations in favor of more combination therapy and ddi with less use of AZT monotherapy for extended periods of time. The results of two sets of studies discussed below illustrate some important points.

Combination of AZT + ddC vs. Monotherapy: The results of ACTG 155,¹⁰ although not surprising in retrospect, added to the gloom of the Berlin International AIDS meeting in 1993. The study compared three different treatment strategies (continue AZT, switch to zalcitabine [ddC] alone, or add ddC to AZT) in 1,001 patients with advanced HIV disease who had been extensively treated with AZT. Overall, there was no survival or clinical advantage to the combination therapy (AZT + ddC) except in the subgroup with a higher CD4+ cell count (150 to 300/mm³). This study had a rigid toxicity man-

agement scheme leading to a high rate of stopping the study drugs. The lengthy period of prior AZT therapy (average=18 months) almost certainly resulted in a high rate of resistance to AZT, meaning that the study probably didn't really look at combination therapy, since only one active drug (ddC) was added to the regimen. Many studies begun since then have required that the patients be ARV naive so that combination therapy with ARV drugs truly is combination therapy (more like the basic rule for the TB treatment model: avoid adding only one active drug to a regimen).

Studies of AZT and 3TC: Four clinical studies (not yet published) examine the combination of AZT + 3TC compared with monotherapy with those drugs.¹¹ Cumulatively, the results seem to indicate that the combination had a more pronounced effect than monotherapy on CD4 counts and HIV RNA levels over a 12-month period. Monotherapy with 3TC had not been viewed with promise because of the rapid appearance of mutations at codon 184 (of the reverse transcriptase gene), which conferred drug resistance.

Fortunately, preliminary data suggest that the 184 mutation somehow leads to an enhanced antiviral effect of AZT, even in HIV strains with existing mutations ordinarily associated with AZT resistance (perhaps through a conformational change in the structure of the reverse transcriptase gene). Studies to confirm the treatment's clinical merit are underway.

ARV DRUGS UNDER STUDY

The ARV drugs that will likely be licensed in the next one to three years fall into three categories:

Nucleoside ARV drugs: 3TC is currently available under a compas-

Table 4

General ARV treatment recommendations 1995**New patients—asymptomatic**

Recommend full medical, laboratory evaluation and discussion of treatment options with patient. Often follow for one to three months for trends before any decision. Review availability of clinical studies for ARV-naïve patients. Consider that up to 20% of new U.S. infections may involve AZT-resistant HIV strains. 3TC currently only available for patients with CD4 count $<300/\text{mm}^3$.

Start with AZT, ddI, or D4T monotherapy for first six months then re-evaluate.

New patients—symptomatic

Start with AZT + 3TC or ddI or ddC. Re-evaluate at six months.

Established patients—progressing

AZT + 3TC or other two- to three-drug combination attempting to switch every six to 12 months depending on clinical status and laboratory markers.

It is likely that new ARV drugs will be available in the next 12 months, offering additional options for combination therapy.

For HIV Clinical Trial information in Minnesota, call 612/221-1280.

sionate-use protocol. It will likely be used mainly as part of combination therapies. The BID dosing is convenient, and the drug is usually well tolerated.

Non-nucleosides reverse transcriptase inhibitors (NNRTIs): As a class, these drugs are associated with the rapid emergence of resistance, so major use will be in combination therapy. The two major NNRTIs in development, nevirapine (Boehringer) and delavirdine (Upjohn), are associated with skin rashes—a unique reaction usually seen during the first four to eight weeks of treatment.

Protease inhibitors (PIs): (See page 28 for a complete list.) This class is a major focus of current drug development. Saquinavir (Roche) will likely be licensed first. It appears to be more potent than the available nucleosides, but because resistance also is a problem, it likely will be used in combination regimens. The triple combination of AZT + ddC + saquinavir (ACTG 229) had superior antiviral activity compared with various two-drug combinations over a six- to 12-month period, but clinical data are lacking. The dosing is convenient, and the drug is usually

well tolerated. There is concern that use of one protease inhibitor will lead to cross resistance to other PIs. The Abbott and Merck PIs will likely be licensed next, and they may be more potent than saquinavir, but formulation and manufacturing issues may limit their availability.

INDIVIDUALIZED THERAPY

The term “individualized therapy” (IT) refers to a treatment approach that includes measuring each patient’s clinical status and key laboratory markers (particularly CD4+ cell counts and plasma HIV RNA levels) to determine the ARV regimen used.¹² With a growing array of ARV drugs to choose from, the number of possible combinations far outstrips any possibility of clinical trials to fully evaluate them. Thus, under IT, patients serve as their own control. This sounds good in theory, but we have nothing beyond anecdotal evidence to suggest patients actually do significantly better, and the laboratory testing involved is very expensive.

GENERAL ARV TREATMENT RECOMMENDATIONS: 1995-96

The current ARV treatment picture is very complicated and likely to get

worse. Although aggressive early therapy with combinations of drugs is believed to yield the best clinical outcome, this has not been proven and will be difficult to study. The ARV “state-of-the-art” recommendations published in 1993¹³ fall short of current practice standards, particularly since relying on CD4+ cell counts will diminish as a standard. A reasonable approach to initial ARV therapy is summarized in Figure 1.¹⁴ Combination therapy is more costly and toxic, and compliance is difficult. I predict that therapy will increasingly involve a strategy of switching drugs/combinations every six to 12 months. Table 4 provides a general overview of my approach. Patients should be actively involved in decisions about their treatment, which is often influenced strongly by the patient’s own treatment philosophy.

PREVENTION AND TREATMENT OF OPPORTUNISTIC INFECTIONS

The U.S. Public Health Service has just published a set of guidelines for the prevention of HIV-related opportunistic infections (OIs), which I recommend as an overview of this complicated area.^{15,16} The CD4+ cell count remains a useful marker for assessing risk for HIV-related OIs and can help guide efforts at primary prophylaxis or evaluation of clinical problems. Figure 2 provides an overview of how to approach OI prevention based on CD4+ cell counts.

The primary care physician’s two most important responsibilities regarding HIV-related OIs involve the prevention and treatment of PCP and the identification of tuberculosis in HIV-infected patients. If tuberculosis is suspected, the patient should be placed in respiratory isolation, and family members and health care workers should take precautions until the diagnosis is ruled out. Tuberculosis in the HIV-infected person is a potential public health emergency that calls for the immediate involvement of specialists with experience in treating those patients.

PNEUMOCYSTIS CARINII PNEUMONIA
Primary prophylaxis of *Pneumocystis carinii* pneumonia (PCP) remains

At any CD4 count

Early intervention begins as soon as you learn your HIV status. Begin by reducing stress—talk openly about HIV with friends, family, a counselor, or your physician; you may be surprised at how just talking about it can relieve anxiety.

Monitor your CD4 count every four to six months. If your CD4 count is high, you may still want to have some "baseline" tests done: Ask your physician about getting a screening for sexually transmitted diseases, even if you have no symptoms. Other baseline tests include a toxoplasmosis titer, a tuberculosis PPD test, and anergy skin testing. Women should also have a vaginal exam and Pap smear done.

Consider reducing alcohol and drug use as well as quitting smoking.

Many physicians continue to recommend that AZT therapy begin at 500 CD4 cells, although some physicians may choose an alternative.

Symptoms

Regardless of CD4 count, alert your physician if you regularly experience diarrhea, fatigue, night sweats, fever, yeast infections or thrush, weight loss, rashes, swollen glands, dry cough.

The new federal guidelines recommend initiating AZT therapy when symptoms begin, but the decision is yours. If you have already been taking AZT and symptoms develop, the guidelines recommend switching to ddI or adding ddI to AZT.

If your symptoms include thrush or a rapidly declining CD4 count, physicians recommend beginning prophylaxis against *Pneumocystis carinii* pneumonia (PCP). The preferred prophylaxis is TMP-SMX (Bactrim, Septra). If you cannot tolerate or be desensitized to this drug, your physician will recommend dapsone or pentamidine.

CD4 count

Under 200

Or CD4 percentage under 20 percent. Monitor CD4s every four months.

At this CD4 count, federal guidelines recommend beginning PCP prophylaxis and AZT therapy even if you have no symptoms. If you are progressing on AZT, switch to ddI monotherapy or add ddI or ddC to AZT. Get regular eye and dental exams.

CD4 count

Under 100

Or CD4 percentage under 10 percent. Monitor CD4s every three months.

Begin prophylaxis against *Mycobacterium avium* complex (MAC) using rifabutin or clarithromycin. Ask about toxoplasmosis and fungal prophylaxis. If you are progressing on AZT, federal guidelines recommend switching to ddI or ddC.

a high priority and may be the most important single aspect of HIV therapeutics. The results of ACTG 081¹⁷ indicate that Trimethoprim-Sulfamethoxazole (TMP-SMX) is the most effective prophylactic regimen, but a significant minority of patients experience adverse effects and require other therapy (usually dapsone or aerosolized pentamidine). Once the CD4+ cell count is $<50/\text{mm}^3$, the risk for breakthrough PCP is increased, even in patients taking TMP-SMX. In patients who react adversely to TMP-SMX, efforts to desensitize them to TMP-SMX are often successful. I recommend that a lower dose (one regular-strength TMP-SMX/day) can generally be used for PCP prophylaxis with equal efficacy and fewer side effects. Atovaquone (Mepron) is being studied for PCP prophylaxis. A liquid formulation appears to be better absorbed, but the high cost is a deterrent to its regular use. The most common error I observe in the treatment of patients with PCP is omitting the use of corticosteroids for patients with severe PCP.¹⁸

FUNGAL INFECTIONS

Prophylaxis for major HIV-related deep fungal infections typifies how frustrating treatment of advanced HIV disease has become. The results of ACTG 981¹⁹ clearly demonstrated that oral fluconazole can reduce the rate of serious fungal infections, yet there was no impact on survival. A cost analysis from that study suggested that use of fluconazole routinely for persons with CD4 counts $<100/\text{mm}^3$ would cost almost \$100,000 for each major infection prevented. Further complicating matters, resistance of fungal isolates to antifungal agents appears to be increasing; as a result, physicians are more often using topical agents or the less expensive ketoconazole for treating thrush—i.e., clotrimazole troches—reserving the other systemic drugs for refractory or more serious cases.

MYCOBACTERIUM AVIUM-INTRACELLULARE (MAI)

MAI bacteremia and disease is a common complication seen in patients

Figure 2—Early-intervention and prevention chart. Reprinted with permission from Positively Aware, November/December 1994. © 1994 Test Positive Network.

with a CD4 $<100/\text{mm}^3$. Rifabutin is licensed for the prevention of MAI, but use has been limited because of concerns about cost, toxicity, resistance, and efficacy (since the study leading to licensure found a reduction in bacteremia rate but no survival benefit). Clarithromycin and azithromycin also are being used for preventing and treating MAI disease, but the role of these newer macrolide agents is still being defined. For persons without liver disease, rifabutin may be the preferred prophylactic agent, reserving the macrolides for treating breakthrough MAI bacteremia/disease. Interestingly, recent observations suggest that MAI disease is predictive of cytomegalovirus disease and vice versa, for reasons that are unclear. Noteworthy drug interactions occur between rifabutin, clarithromycin, and fluconazole, i.e., fluconazole and clarithromycin increase rifabutin levels.

CYTOMEGALOVIRUS

Cytomegalovirus (CMV) infections are a serious HIV-related infection, particularly in patients with CD4 $<50/\text{mm}^3$. A recently completed study of oral ganciclovir concluded that it was nearly as effective as IV ganciclovir at delaying reactivation of CMV retinitis. Another study of the prophylaxis of CMV disease found that oral ganciclovir reduced the rate of CMV disease by nearly 50%. Problems associated with oral ganciclovir include its cost (up to \$20,000/year) and toxicity (particularly hematologic). Resistance of CMV isolates to ganciclovir is a potential problem. Intravenous foscarnet remains a useful but expensive treatment for CMV disease. Combination therapy with foscarnet and ganciclovir is sometimes useful in cases refractory to either agent alone. There is renewed interest in local treatments of CMV retinitis with implants or injections. A new anti-CMV drug under development is Cidofovir (HPMPC), which can be used for intravenous or intravitreal therapy. Cidofovir appears to have considerable renal toxicity but has a long half-life, allowing dosing at weekly intervals.

MOPPS THERAPY

The permanent severe immune suppression seen in AIDS and the wide range of potential opportunistic infections (OIs) has led to interest in preventing multiple OIs (MOPPS= multiple opportunistic pathogens prophylaxis studies). Recent concerns about emerging resistance of microbes to standard treatments and the high cost and polypharmacy pose many challenges. The dogma that prevention is always better is being replaced by renewed interest in trying to target OI prophylaxis better by using CD4 criteria and serologic studies, i.e., CMV antibody positivity, the presence of associated OIs, or avoidance of exposures through behavior changes.^{15,16} Like ARV therapy, the prevention and treatment of HIV-related infections is complex. I recommend that physicians with a low HIV case load link up with an HIV specialist to help sort out the various issues.

NUTRITION: AIDS-RELATED WASTING

AIDS wasting syndrome, defined as involuntary loss of $>10\%$ of lean body mass, is a major complication of AIDS and is an independent predictor of death. Rapid weight loss due to decreased nutrition is often associated with secondary infections. Slower weight loss is often related to gastrointestinal tract abnormalities (including diarrhea). It is believed that early diagnosis and treatment of OIs and GI symptoms is a crucial factor in maintaining nutritional status. Fewer studies have researched the clinical benefit of aggressive nutritional support in the HIV-infected patient.^{20,21}

Although I recommend that HIV patients take one to two multiple vitamins a day, there is no firm data proving whether that is beneficial. When patients begin to lose weight involuntarily, I recommend asking a nutritional consultant to help the patient optimize caloric intake while the physician evaluates the patient for OIs and GI problems. Several medications have been approved (Megace and Marinol) for the palliation of AIDS-related wasting syn-

drome, but neither has been shown to improve survival or increase lean body mass. The potential of mammalian cell-derived growth hormone to treat AIDS-related wasting is currently being evaluated. Preliminary results suggest that growth hormone can increase lean body mass for some patients, but the treatment is very expensive (up to \$1,000 a week). Thalidomide is also being studied for its effect on wasting.

SYMPTOM MANAGEMENT

The HIV caregiver, besides having a working knowledge of all the topics discussed above, has to be a compassionate and supportive listener with a generalist's breadth of knowledge about the tools available to relieve a patient's symptoms. Major symptom categories encountered in HIV/AIDS patients include: psychiatric (depression, insomnia, anxiety); gastrointestinal (nausea, vomiting, diarrhea, constipation); and pain. Care of the patient with advanced disease calls on all the physician's personal skills. My observations suggest that treatment of pain in patients with advanced AIDS is a particularly neglected area.²² Helping the terminally ill AIDS patient prepare for death is a challenging and rewarding endeavor, yet one that leads to a high risk of professional burnout. Teamwork is essential to providing seamless care to patients in a variety of settings, and it helps to maintain caregivers' morale.

CONCLUSION

How can physicians make some sense of complex HIV therapeutics? Prevention of HIV infection should be the cornerstone of our efforts as a society. Early diagnosis of HIV infection also is critical so that patients can take advantage of treatment advances. Primary care physicians have a major role in HIV prevention and early diagnosis and intervention efforts, yet studies suggest that many primary care physicians are not adequately providing basic HIV primary and preventive care. In addition, outcomes from AIDS-related complications, such as PCP, may be better at sites with more experience.^{23,24,25} For the HIV caregiver with little experi-

ence, it is crucial to link up with an experienced HIV caregiver to facilitate patients' access to optimal treatments and clinical studies. For the experienced HIV caregiver, it is important to contribute to the research effort to help resolve some of the vexing therapeutic dilemmas faced by physicians and patients. Since the HIV epidemic has become an endemic infection of the U.S. population, AIDS will be a health threat for decades to come. Physicians need to be unrelenting in their efforts to improve the care of HIV-infected patients while working to prevent new infections.

MM

Keith Henry is director of the HIV/AIDS Clinic and Programs at Health-Partners St. Paul-Ramsey Medical Center and an associate professor with the University of Minnesota Medical School. He also serves as medical director for the St. Paul Department of Health's HIV and Sexually Transmitted Disease Clinic and is involved with the AIDS Clinical Trials Group sponsored by the National Institute of Allergy and Infectious Diseases.

REFERENCES

1. Broder S, Merigan TC, Bolognesi D. Textbook of AIDS medicine. Baltimore, Maryland: Williams & Wilkins, 1994.
2. Fischl MA, Richman DD, Grieco MH, et al. The efficacy of azidothymidine (AZT) in the treatment of patients with AIDS and AIDS-related complex: a double-blind, placebo-controlled trial. *N Engl J Med* 1987;317:185-91.
3. Spooner KM, Lane HC, Masur H. Antiretroviral therapy: reference guide to major clinical trials in patients infected with human immunodeficiency virus. *Clin Infect Dis* 1995;20:1145-51.
4. Ioannidis JPA, Cappelleri JC, Lau J, et al. Early or deferred zidovudine therapy in HIV-infected patients without an AIDS-defining illness. *Ann Intern Med* 1995;122:856-66.
5. Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. *N Engl J Med* 1994;331:1173-80.
6. Rogers MF, Jaffe HW. Reducing the risk of maternal-infant transmission of HIV: a door is opened [Editorial]. *N Engl J Med* 1994;331:1222-3.
7. Recommendations of the U.S. Public Health Service Task Force on the use of zidovudine to reduce perinatal transmission of human immunodeficiency virus. *MMWR* 1994;43:1-20.
8. Erice A, Balfour HH. Resistance of human immunodeficiency virus type 1 to antiretroviral agents: a review. *Clin Infect Dis* 1994;18:149-56.
9. Mellors JW, Larder BA, Schinazi RF. Mutations in HIV-1 reverse transcriptase and protease associated with drug resistance. *Int Antiviral News* 1995;3:8-13.
10. Fischl MA, Stanley K, Collier A, et al. Combination and monotherapy with zidovudine and zalcitabine in patients with advanced HIV disease. *Ann Intern Med* 1995;122:24-32.
11. James JS. 3TC plus AZT: important treatment advance? *AIDS Treatment News* 1994;212:1-4.
12. Thompson MA. Individualized therapy: the role of viral-burden measures. *Hosp Pract* 1995;30 (Suppl 1):41-50.
13. Sande MA, Carpenter CC, Cobbs G, et al. Antiretroviral therapy for adult HIV-infected patients. *JAMA* 1993;270:2583-9.
14. Grodeck B. A consumer's guide to fighting HIV. *Positively Aware* 1995;May/June:11.
15. Centers for Disease Control. USPHS/IDSA guidelines for the prevention of opportunistic infections in persons infected with human immunodeficiency virus: a summary. *MMWR* 1995;44:1-34.
16. Infectious Disease Society of America. Prevention of opportunistic infections in persons infected with human immunodeficiency virus. *Clin Infect Dis* 1995;21(Suppl 1):1-140.
17. Bozzette SA, Finkelstein DM, Spector SA, et al. A randomized trial of three antipneumocystis agents in patients with advanced human immunodeficiency virus infection. *N Engl J Med* 1995;332:693-9.
18. NIH-University of California Expert Panel. Special report: consensus statement on the use of corticosteroids as adjunctive therapy for pneumocystis pneumonia in the acquired immunodeficiency syndrome. *N Engl J Med* 1990;323:1500-4.
19. Powderly WG, Finkelstein DM, Feinberg J, et al. A randomized trial comparing fluconazole with clotrimazole troches for the prevention of fungal infections in patients with advanced human immunodeficiency virus infection. *N Engl J Med* 1995;332:700-5.
20. Macallan DC, Noble C, Baldwin C, et al. Energy expenditure and wasting in human immunodeficiency virus infection. *N Engl J Med* 1995;333:83-8.
21. Grunfeld C. What causes wasting in AIDS? [Editorial]. *N Engl J Med* 1995;333:123-4.
22. Stansell JD, Follansbee SE. Management of late-stage AIDS. In: Sande MA, Volberding PA, eds. The medical management of AIDS. 4th ed. Philadelphia: W.B. Saunders Co., 1995:665-79.
23. Curtis JR, Paauw D, Wenrich MD, et al. Physicians' ability to provide initial primary care to an HIV-infected patient. *Arch Intern Med* 1995;155:1613-8.
24. Samet JH, Libman H, LaBelle C, et al. A model clinic for the initial evaluation and establishment of primary care for persons infected with human immunodeficiency virus. *Arch Intern Med* 1995;155:1629-33.
25. Bennett CL, Gerfinke JB, Greenfield S, et al. The relation between hospital experience and in-hospital mortality for patients with AIDS-related PCP. *JAMA* 1989;261:2975-9.

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?

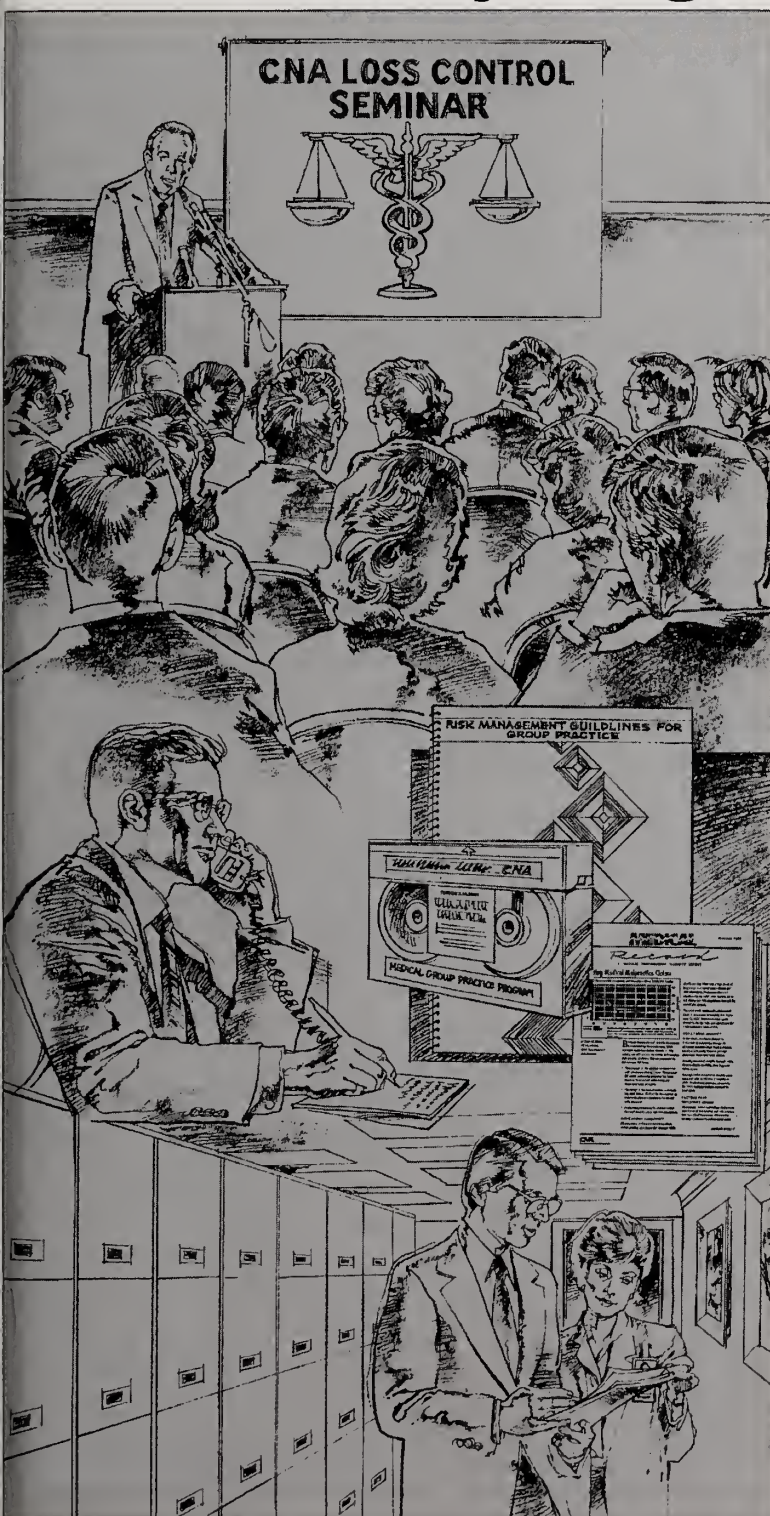


Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

PREVENTIVE MEDICINE FROM CNA:

Risk management for the changing needs of your group practice.



At CNA, we believe that effective risk management is the cornerstone of any professional liability insurance program. That's why we have developed a broad and flexible risk management program to meet the changing needs of your medical group practice.

Our program helps protect your reputation and control your premium cost by showing you and your staff how to minimize your exposure to loss. We do this by offering regional educational seminars, video and journal reference materials, newsletters, telephone consultations and even on-site surveys. And, by attending one of our Medical Loss Control Seminars, you even receive a premium discount.

**CNA
MEDICAL
GROUP
PRACTICE
PROGRAM**

We have the expertise and resources to help your group practice now and as your needs change. For more information about medical group practice professional liability insurance from the CNA Insurance Companies, contact your local broker or:

The CNA Insurance Companies
Professional Liability Group, 19S
CNA Plaza
Chicago, IL 60685
(312) 822-5000

CNA

For All the Commitments You Make®

Program underwritten by property/casualty companies of the CNA Insurance Companies/CNA Plaza/Chicago, IL 60685. CNA is a registered service mark of the CNA Financial Corporation.

Directions in HIV/AIDS Research

A Minnesota Perspective

Keith Henry, M.D., Holly Melroe, R.N., and Ray Nelson, R.N.

ABSTRACT

Clinical studies involving HIV therapeutics are becoming ever more challenging because of the changing epidemiology of HIV infection, the rapid evolution of standard clinical practice, and a more difficult economic environment for research. Recent studies relating to HIV pathogenesis have provided novel insights into the interactions between HIV, the immune system, and antiretroviral therapies. Current dogma now suggests that the interaction of HIV and the immune system is an incredibly dynamic process. HIV is an intimidating pathogen capable of replicating quickly and mutating very rapidly in response to antiretroviral therapy. An important question being studied by Minnesota-based investigators is how well plasma analysis reflects HIV-immune system interactions in the lymphoid tissue where most virus and CD4+ (T-helper) cells are located. Most of the HIV clinical studies in Minnesota are conducted under the auspices of the AIDS Clinical Trials Group (ACTG) or the AIDS Research Consortium of the Twin Cities (ARCTIC). Much expertise is available in Minnesota addressing a wide range of topics, from epidemiology, to basic virology, to prevention. To optimize patient access to clinical studies, we recommend that physicians discuss available clinical studies with an HIV investigator soon after first seeing a new HIV-infected patient.

Although a tremendous amount of information pertaining to the HIV epidemic has been acquired over the 14 years since AIDS was recognized, HIV infection remains incurable. New insights into HIV pathophysiology and the development of many potent new antiretroviral (ARV) therapies have generated much excitement among investigators over the last several years, but the advances have been difficult to apply to clinical practice. The gap between scientific advances and the day-to-day treatment of HIV-infected patients frustrates clinicians and patients. Much of the current research is focused on making scientific advances more clinically relevant. In this article we summarize some of the most significant developments in HIV research and provide an overview of HIV research in Minnesota.

The changing epidemiology of the HIV/AIDS epidemic poses further challenges to the research community. A special concern is the disproportionate rates of infection among African-Americans and Hispanic-Americans, who make up nearly 50% of recent U.S. AIDS cases (including nearly 75% of women and 80% of children with AIDS). In Minnesota, 19% of the recent AIDS cases and 30% of the recent HIV non-AIDS cases have been in African-Americans. Increasingly, HIV-infected patients we see at St. Paul-Ramsey Medical Center have associated psychiatric or chemical dependency problems. Many of these patients have significant problems obtaining medical care because of social and financial barriers. Caring for these special populations places new demands on the medical research team, which must deal with such issues as providing daycare or family care during

appointments or helping patients obtain social services.

THE KINETICS OF HIV REPLICATION

The most interesting developments in the field of HIV research relate to recently published observations examining the rate at which new HIV particles are produced and cleared in an infected patient. Studies of primary HIV infection had revealed startlingly high levels of HIV in the plasma prior to clearance by the immune system.¹ Next, several sentinel papers (one from the University of Minnesota group led by Ashley Haase, M.D.) revealed that extremely high levels of HIV were present in lymphoid tissue even in the period of clinical latency.^{2,3}

The next technologic step forward was the development of more sensitive methods to quantitate HIV levels in the plasma.^{4,5} Those developments provided the foundation for studies examining the impact of antiretroviral therapy on levels of HIV RNA in plasma, which allowed analyses of the kinetics of HIV replication to be performed.⁶⁻⁸ Interpretation of these types of studies assumes that there are two copies of HIV RNA per virion. Whereas the effect of AZT (zidovudine) on HIV RNA levels is generally modest, use of several of the protease inhibitors (PIs) resulted in decreases of almost 99% in plasma HIV RNA levels. Major findings from those studies suggest that the rate of HIV production per day is 10^8 to 10^9 in a typical infected patient, with a calculated HIV half-life of two days. Similar analyses of the rate of CD4+ cell increases seen after patients were started on a protease inhibitor concluded that CD4+ cells were produced at a rate

of 2×10^9 cells per day. These results suggested that there was a very dynamic and previously unimagined relationship between HIV turnover and CD4+ cell production.

One major question that evolved from these studies was, "Why is there a 1% residual rate of viremia despite the effect of these more potent drugs?" Possible explanations include poor penetration of the drug into tissues, the existence of a population of long-living HIV-producing cells, a low continuous rate of activation of latently infected cells, or a drug-resistant virus. HIV drug resistance is a major obstacle to the development of more effective therapy. It is estimated that HIV mutates at each base pair of its genome every 10^4 to 10^5 replications; thus, it is conceivable that almost every possible mutation could occur each day, leading to a massive number of HIV variants. Table 1 summarizes the implications of drug resistance for treatment.

Conceivably, the high rate of CD4+ cell turnover may wear the body out over time. Treatment with drugs that only modestly reduce HIV production can potentially have a major impact on the period of clinical latency. Furthermore, if a mutant virus (drug resistant) doesn't grow as well as the original "wild-type" strains, then continued use of drugs even after resistance has developed may be beneficial. Several research groups at the University of Minnesota (Table 2) are studying HIV pathogenesis. Of cardinal importance are studies examining at the tissue level the kinetics of HIV replication and distribution, so far only indirectly measured by studies of HIV in the plasma compartment. The vast majority of HIV in the body is located in the lymphoid tissues, where the concentration of HIV based on our studies may be 10^3 to 10^4 higher than in the blood on a gram-per-gram basis. Perhaps the most critical studies will be those examining the association between a drug's effect on plasma HIV RNA and the ultimate clinical outcome.

CLINICAL STUDIES

Clinical studies of HIV therapies generally focus on one of three broad

Table 1

High rate of HIV replication/mutation: implications for therapy

Mutation is an inevitable result of antiviral therapy.

The appearance of mutant virus causes drug failure.

Most mutations already exist at low levels.

No matter how effective the drug, clinical benefits will be transitory.

Drug-resistant mutants often don't grow as well as wild-type HIV.

There may be drug combinations that result in "best mutations" that effectively cripple the virus.

The high rate of CD4+ cell turnover caused by HIV wears out the body over time.

Even a modest decrease in HIV replication might lead to a significant lengthening of the clinical latency period.

In the case of AZT, the mutant virus (resistant) appears to grow similarly to wild type (sensitive) virus, thus any benefit is transient.

Coffin JM. HIV population dynamics in vivo: implications for genetic variation, pathogenesis, and therapy. *Science* 1995;267:483-9.

Table 2

HIV virologic/immunopathogenesis-based research in Minnesota

University of Minnesota HIV Laboratory

Research interests:

- quantification of HIV levels in blood
- studies of HIV virulence
- resistance of HIV to drugs (genotypic/phenotypic)
- correlation of anti-HIV treatment and viral markers
- quantification of HIV levels in lymphoid tissues

Contacts: Henry Balfour, M.D., 612/626-5670, and Aleja Erice, M.D., 612/626-0920

University of Minnesota Department of Microbiology

Research interests:

- identification of HIV in tissues, e.g., brain and lymph tissues
- development of technologies to measure HIV levels/activity in tissues
- pathogenetic mechanisms

Contact: Ashley Haase, M.D., 612/624-4442

St. Paul-Ramsey Medical Center HIV Program

Research interests:

- quantification of HIV levels in tissues
- methods of obtaining lymphoid tissues
- effect of splenectomy on HIV levels
- physical treatment (heat, etc.) of HIV infection

Contact: Keith Henry, M.D., 612/221-1280

Table 3

Ongoing Protease Inhibitor Trials

The following are trials that are either enrolling now or will do so in the near future:

Company	Trial	Size and Start Date	Criteria
Roche saquinavir Contact 800/526-6367	Phase 3 study of AZT, AZT + ddC, saquinavir + AZT or all three combined	3,000 people – 1,700 already enrolled. Sites across Europe, Israel, Mexico, Canada, Australia, Brazil, Argentina and 37 sites in the U.S.	CD4 count 50–350 No prior antiretroviral drug except AZT for 16 weeks maximum
Merck MK-639 (formerly L-524) Contact Linda Distlerath 908/423-4165 John Daarley 908/423-4081 Jon Weiner 215/652-6462	MK-639, AZT or the two combined	750 people Study will begin in April in Brazil	CD4 count 50–250 AZT-naïve
	MK-639, AZT or the two combined	780 people Screening and enrollment has begun in the U.S. Study also will take place in Europe and Canada	CD4 count 50–500 AZT-naïve
	MK-639, d4T or the two combined	540 people Study is taking place in the U.S., also will take place in Europe	CD4 count 50–500 AZT-experienced
	MK-639, AZT/3TC or all three combined	90 people Enrollment began in April in the U.S.	CD4 count 50–400 AZT-experienced
	MK-639, AZT + 3TC or all three. Open-label MK-639 for ineligible applicants	300 people Enrollment in June in the U.S. Will expand the open-label arm to at least 1,400 persons by the end of the year	CD4 count under 50
	MK-639 with probably d4T or AZT/3TC as the control	Large study to be conducted in the U.S. and Europe, possibly Canada and Australia	AZT-experienced
Abbott ABT-538 Contact Abbott 312/755-1241	Phase 3 study of enrollees' current antiviral(s) + ABT-538 or placebo	700 persons Sites in Europe, Australia and the U.S.	CD4 count under 100 AZT-experienced
	Phase 3 study of AZT, ABT-538 or the combination of both	900 persons (subject to change)	CD4 count undetermined as yet AZT-experienced
National Cancer Institute Contact: Kathy Wyvill 800/772-5464	A phase 1 study of KNI-272. Drug will be IV for the first 3–7 days, then oral only for up to 12 weeks	(Volunteers will be admitted to the NIH Clinical Center in Bethesda, MD for the study's first 3–7 days)	CD4 count 100–400 Must be off anti-HIV therapy for prior 3 weeks and free of active opportunistic infection
Agouron AG1343 Contact 800/501-2474 Prepared by Wendee Rogerson	A 28-day dose-ranging study	30 persons, 15 per site (New York and San Francisco) Begins in July	CD4 count over 200 No antiviral for the past year
	The following three studies under consideration:		
	A placebo-controlled dose-ranging study	225 persons Study will begin in the fall	CD4 count over 50 Asymptomatic
	A study of d4T and d4T + high or low dose 1343	150 persons Study will begin in the fall	CD4 count 50–300; d4T-naïve, AZT-naïve or -experienced
	A study comparing standard of care with or without 1343	280 persons Study will begin in the fall	CD4 count less than 50 No prior protease therapy

Reprinted with permission from GMHC Treatment Issues, June 1995. © 1995 Gay Men's Health Crisis, Inc.

areas: antiretroviral therapies, prevention and treatment of HIV-associated infections or tumors, or the treatment of symptoms (wasting, neuropathy, etc.). Studies of anti-HIV drugs have the highest priority because investigators and clinicians believe effectively inhibiting HIV replication will avert the secondary problems associated with advancing immune deficiency. Current interest is highest in the class of drugs known as protease inhibitors (PIs). Since the atomic structure of HIV protease was elicited in 1990,⁹ a massive effort has been underway to design drugs that inhibit its activity. Several of the PIs used as monotherapy appear much more effective at decreasing HIV RNA levels in the plasma than the available nucleoside reverse transcriptase inhibitors. Table 3 summarizes the status of clinical PI studies.

Most clinical studies in Minnesota are conducted by either the University of Minnesota AIDS Clinical Trials Unit (see Table 4 for information and a list of active studies) or the AIDS Research Consortium of the Twin Cities (ARCTiC—see Table 5). As *Minnesota Medicine* goes to press, we are awaiting the final results of three major studies addressing the clinical benefit of combination ARV therapy versus monotherapy (ACTG 175, CPCRA 007, and the European Delta Study), which should provide direction concerning the potential benefits of currently available therapy. Preliminary results from ACTG 175 and the Delta Study confirm the superiority of combination therapy compared with ZDV monotherapy. The combination of AZT and D4T is being compared with other therapies in ACTG 290. The combination of AZT and 3TC, intriguing because of the effect the 184 codon site mutation (which confers resistance to 3TC) has on regaining sensitivity to AZT,¹⁰ will be studied in numerous trials soon to be available, including ACTG 302 and 303. Many of the current ARV trials are researching combination therapy with non-nucleoside reverse transcriptase inhibitors (nevirapine in ACTG 193 A and ACTG 244 or delavirdine in ACTG 261 and the Upjohn studies at the ARCTiC sites). Several of the PIs have been

Table 4

AIDS Clinical Trials Group (ACTG)
NIH-sponsored HIV/AIDS research protocols

Contacts

University of Minnesota, 612/625-1462
St. Paul-Ramsey Medical Center, 612/221-1280
Hennepin County Medical Center, 612/347-2705

Open to enrollment

ACTG 193A—A randomized, double-blind, four-arm study comparing combination nucleoside, alternating therapy and triple therapy for treatment of advanced HIV disease

ACTG 223—A prospective, multicenter, randomized, controlled trial comparing the safety and efficacy of three clarithromycin-containing combination drug regimens for the treatment of disseminated *Mycobacterium avium* complex (MAC) disease in persons with AIDS

ACTG 242—A double-blind study of amitriptyline and mexiletine for painful neuropathy in HIV infection

ACTG 244—A double-blind, randomized trial comparing zidovudine (ZDV) vs. ZDV + didanosine (ddl) vs ZDV + ddl + nevirapine in asymptomatic patients on ZDV monotherapy who develop a mutation at codon 215 in HIV reverse transcriptase in serum/plasma viral RNA

ACTG 267—A placebo, controlled-dose escalation study of the safety, tolerability, and pharmacokinetics of thalidomide in subjects with HIV-1 infection

ACTG 268—Gradual initiation of Trimethoprim/Sulfamethoxazole as primary *Pneumocystis carinii* pneumonia prophylaxis

ACTG 290—A randomized study of the virologic and immunologic effects of D4T vs. ddl vs. zidovudine + D4T vs. zidovudine + ddl in HIV-infected patients with CD4 cell counts between 300 and 600 and greater than 24 weeks of zidovudine experience

Closed to enrollment/patients being followed

ACTG 261—A randomized, double-blind study of delavirdine mesylate (DLV) in combination with zidovudine (ZDV) and/or didanosine (ddl) vs. ZDV and ddl combination therapy

ACTG 277—A randomized, comparative study of daily Dapsone and daily atovaquone for prophylaxis against PCP in HIV-infected patients who are intolerant of Trimethoprim and/or sulfonamides

Pending protocols

ACTG 302—A double-blind study of virologic responses to new nucleoside regimens after prolonged ZDV or ddl monotherapy

ACTG 303—Influence of risk status for disease progression on the response to antiretroviral intervention: a follow-up study to ACTG 175 multicenter trial of the AIDS Clinical Trials Group

studied or will be studied in clinical trials conducted in Minnesota (saquinavir in ICC 001 and Agouron 1343 at ARCTiC sites). Many new HIV therapies are made available under a Treatment IND (parallel-

track or compassionate-use) mechanism available to individual practitioners while pivotal clinical studies are in progress. As of this writing, the Merck PI Crixivan (indinavir) and the Roche PI saquinavir have been

Table 5

**AIDS Research Consortium of the Twin Cities (ARCTiC)
Industry-sponsored HIV/AIDS research protocols****Contacts**

Park Nicollet Clinic—HealthSystem Minnesota, 612/993-3508
 St. Paul-Ramsey Medical Center, 612/221-1280
 Hennepin County Medical Center, 612/347-2705

Open to enrollment

Double-blind randomized study of delavirdine in combination with ZDV vs. ZDV alone.

Study sponsor: Upjohn

Double-blind randomized study of delavirdine in combination with ddI vs. ddI alone.

Study sponsor: Upjohn

Master protocol to evaluate the safety and efficacy of multidrug combinations, including ZDV, ddC, and saquinavir for the treatment of HIV infection.

Study sponsor: Parxel (ICCADD)

Open-label study to provide expanded access to obtain additional safety on Serostim (growth hormone) in the treatment of adults with advanced AIDS wasting.

Study sponsor: Serono Laboratories

Pending protocols

Treatment of HIV infection with AG 1343 (protease inhibitor).

ment of PCP. ACTG 268 compares standard TMP-SMX to dose titration methods for “desensitizing” patients in an effort to decrease the rate of adverse reactions to TMP-SMX. For patients with established sensitivity to TMP-SMX, ACTG 277 is comparing atovaquone (Mepron) to Dapsone for PCP prophylaxis. The results of a major trial (ACTG 194) comparing various regimens for MAI prophylaxis should be available this fall, and a study comparing various oral regimens for active MAI is still open (ACTG 223). For the treatment of CMV retinitis, Herbert Cantrill, M.D., is conducting studies of the ganciclovir implant, and University of Minnesota researchers are studying a new anti-HIV drug (BMS 180, 194). CMV interests several University of Minnesota investigators (quantitation and resistance: Alejo Erice, M.D., and Henry Balfour, M.D.; pathogenesis: Colin Jordan, M.D.).

**NON-INFECTIOUS
COMPLICATIONS OF HIV**

Major non-OI complications of HIV that significantly affect morbidity and mortality include AIDS-related dementia, AIDS-related wasting, and HIV/AIDS-related neuropathy and pain syndromes. Efforts to better understand AIDS-related dementia have been spearheaded in Minnesota by Richard Price, M.D., at the University of Minnesota.¹² AIDS-related wasting syndrome is a complicated subject linking a wide range of factors from nutrition to cytokine abnormalities.^{13,14} The ARCTiC group plans to participate in studies involving mammalian cell-derived growth hormone (Serono Laboratories) starting this fall to better elucidate the role of growth hormone in the treatment of wasting syndrome. Peripheral neuropathy is a common symptom seen in AIDS patients. Mexiletine is being compared with amitriptyline for the treatment of painful neuropathy at the ACTG sites in Minnesota (ACTG 242, see Table 4).

EPIDEMIOLOGIC STUDIES

Since the beginning of the AIDS epidemic, the Minnesota Department of Health (MDH) has carefully tracked

made available through a lottery IND system. Table 6 lists contacts specializing in certain ARV therapies.

Local researchers are also studying immune-based therapies (see Table 6). Thalidomide is being evaluated in one study (ACTG 267) for its effect on HIV replication as a possible inhibitor of tumor necrosis factor. Lisa Filapovich, M.D., is interested in studying cord blood as a source of stem cells for later use in the treatment of pediatric HIV infection. St. Paul-Ramsey's HIV/AIDS Programs have enrolled several HIV-infected patients in gene therapy studies being conducted at the NIH Clinical Center. A major issue concerning the immunology of HIV-related immune damage relates to the functional status of CD4+ cells that increase in numbers after HIV replication has been suppressed by ARV therapy. Researchers are concerned that the CD4+ cells are clonally limited and, thus, may not function properly to suppress HIV-related opportunistic infections. If that worry is justified, then there will be renewed interest in adjuvant immune-

based therapies to strengthen the function of the immune system.

**INFECTIOUS COMPLICATIONS
OF HIV/AIDS**

The number of specific HIV-related opportunistic infections (OIs) occurring in Minnesota yearly is low by national standards, so studies involving the treatment of particular OIs are more difficult to conduct here than are ARV-based studies.¹¹ Even more difficult is the treatment of the neoplastic complications of AIDS (such as Kaposi sarcoma and non-Hodgkin lymphoma), which are not the subject of any major clinical studies in Minnesota as of this writing. Studies of some of the major OIs such as *Pneumocystis carinii* pneumonia (PCP), *Mycobacterium avium-intracellulare*, and cytomegalovirus are being conducted in the Twin Cities and are listed in Table 7. Since sensitivity to Trimethoprim-Sulfamethoxazole is common in HIV-infected patients, alternative dosing strategies or medications are being studied for the prevention and treat-

the demographics of patients diagnosed with AIDS. Since 1985, HIV+ serostatus has also been reportable to MDH, which publishes a summary of the non-AIDS HIV statistics frequently throughout the year. The AIDS Section at MDH is responsible for contact notification and the evaluation of any unusual exposure and transmission cases. Alan Lifson, M.D., at the University of Minnesota School of Public Health is an expert on the epidemiology of HIV transmission, having formerly been involved with the San Francisco Clinic Cohort Study and the Centers for Disease Control and Prevention.¹⁵ James Neaton, Ph.D., is a statistician in the University of Minnesota School of Public Health who heads a team responsible for statistical support for the National Institute of Allergy and Infectious Diseases' Community Programs for Clinical Research on AIDS (CPCRA). Neaton has proven to be an innovator in clinical trials design. Table 8 summarizes key contacts for HIV-related epidemiologic and behavior studies in Minnesota.

BEHAVIORAL STUDIES

One important area that doesn't get the priority it deserves relates to behaviors associated with HIV transmission and patient access to health care.¹⁶ Aspects of behavior related to safer sexual practices are being studied at the Program for Human Sexuality at the University of Minnesota. Our group at St. Paul-Ramsey Medical Center has been involved in numerous studies related to the behaviors of health care workers that place them at risk for needlestick injuries in the workplace. Prevention efforts in Minnesota and the United States need to focus on promoting safer behaviors in the African-American and Hispanic communities and on clarifying the perception of risk among these populations.

CONCLUSION

The AIDS epidemic, unrecognized 15 years ago, is now a leading cause of death for young people in many U.S. cities (including Minneapolis). Minnesota responded to this new health threat by developing a pro-

Table 6

Areas of research interest

Compassionate antiretroviral open-label programs

3TC:	University of Minnesota, St. Paul-Ramsey Medical Center, Park Nicollet Clinic-HealthSystem Minnesota, Intermed Consultants
Indinavir:	University of Minnesota, St. Paul-Ramsey Medical Center
Saquinavir:	Clinic 42, St. Paul-Ramsey Medical Center

Clinical pharmacology of antiviral drugs

Courtney Fletcher, Pharm.D., and Edward Acosta, Pharm.D., University of Minnesota, 612/624-6489

- Concentration-controlled antiretroviral therapy
- Pharmacokinetic variability of antiretroviral compounds
- Pharmacokinetics in special populations

Women

Kay Schwebke, M.D., St. Paul-Ramsey Medical Center, 612/221-1280

- ZDV pharmacokinetics in pregnant HIV-infected women

Pediatric

Laura Hoyt, M.D., Children's Health Care-St. Paul, 612/220-6444, and University of Minnesota Pediatric Clinic, 612/624-1112

- Randomized comparative study of combinations of ZDV and 3TC vs. the better of ddI monotherapy vs. ZDV plus ddI in symptomatic HIV-1-infected children (proposed)

Immunology of HIV infection

Phil Peterson, M.D., Hennepin County Medical Center, 612/347-2705

- Lab investigation of immunologic issues in HIV infection

Gene therapy in the pediatric population

Lisa Filipovich, M.D., University of Minnesota, 612/624-7686

Mucosal immunity

Ed Janoff, M.D., Veterans Affairs Medical Center, 612/725-2000, ext. 4483

- Intestinal immunity to HIV
- Oral immunity to HIV
- Breast milk and HIV

active public health approach and establishing multiple HIV clinics throughout the Twin Cities area. The HIV research conducted in Minnesota, as highlighted in this article, covers a broad range of interests, from basic immunopathogenesis to sexual behavior. Much of the research is conducted under the auspices of the University of Minnesota, illustrating how public academic health centers serve as a focal point for addressing health problems in

the community.

HIV-focused research has received much attention and funding over the last decade, so it is fair to ask whether the immense effort has yielded dividends. Since there is no cure for HIV/AIDS in the foreseeable future, critics have voiced the opinion that HIV research has received excessive resources and should be scaled back. AIDS research conducted through the National Institutes of Health has been reorganized under

Table 7

Opportunistic infection/complication protocols**ACTG protocols**

ACTG 223—A prospective, multicenter, randomized, controlled trial comparing the safety and efficacy of three clarithromycin-containing combination drug regimens for the treatment of disseminated *Mycobacterium avium* complex (MAC) disease in persons with AIDS

ACTG 242—A double-blind study of amitriptyline and mexiletine for painful neuropathy in HIV infection

ACTG 268—Gradual initiation of Trimethoprim/Sulfamethoxazole as primary *Pneumocystis carinii* pneumonia prophylaxis

ACTG 277—A randomized, comparative study of daily Dapsone and daily atovaquone for prophylaxis against PCP in HIV-infected patients who are intolerant of Trimethoprim and/or sulfonamides

Industry-based protocols

Ganciclovir implant trial: randomized controlled study of the safety and preventive efficacy of oral ganciclovir used in conjunction with intravitreal ganciclovir implant.

Contact: Herbert Contrill, M.D., Vitreoretinal Surgery, P.A., 612/929-1131

Antiviral study of new compound lobuciclovir for HIV patients shedding CMV, with CD4 count <200; oral anti-CMV pharmacokinetics and safety evaluation.

Contact: Colin Jordan, M.D., University of Minnesota Department of Medicine, 612/624-9996

Compassionate-use protocol for treatment of idiopathic GI aphthous ulcers.

Contact: Hanan Rosenstein, M.D., Clinic 42, Abbott Northwestern, 612/863-5336

Open-label study providing access to Serostim (growth hormone) for treatment of wasting.

Contacts: Keith Henry, M.D., St. Paul-Ramsey Medical Center, 612/221-1280, and Paul Carson, M.D., Park Nicollet Clinic-HealthSystem Minnesota, 612/993-3508

the Office of AIDS Research, headed by immunologist William Paul. The Office of AIDS Research is responsible for setting the AIDS research agenda to balance research involving different areas, e.g., basic science versus clinical studies. It is clear that funding for HIV/AIDS research has reached its zenith, so future efforts need to be as efficient and productive as possible. The well-chronicled success of AIDS activism has understandably been a model for other disease-interest groups—for example, breast cancer patients—making the struggle over dividing limited research funds more heated. It seems likely that funding for clinical studies of anti-HIV drugs will increasingly be sponsored by pharmaceutical firms or consortiums. The ICCADD (In-

tercompany Collaboration for AIDS Drug Development) consortium represents a collaboration among 16 of the largest drug companies in the United States as they attempt to accelerate the pace of clinical progress against HIV (ARCTIC was one of the first sites chosen to participate in the network). Many of the industry studies are now quite sophisticated and often match government-funded studies in scientific merit.

HIV-directed research has already had many spin-offs that will affect other diseases. The massive effort to understand the HIV virus has advanced our understanding of retroviruses and other viruses. Retroviruses are the vectors for many gene therapy applications, targeting a wide variety of diseases. Retroviruses are

believed to be the original source of many oncogenes now linked to an increasing number of cancers. Technologies developed for the detection and quantitation of HIV can be applied to other viruses. At the onset of the AIDS epidemic, the field of clinical virology was limited, with only acyclovir available for the treatment of viral infections. Viruses, which cause numerous conditions previously difficult to diagnose and treat, are now viewed differently in the midst of the HIV epidemic. There are now four licensed ARV drugs available, with another half-dozen likely to be licensed over the next several years. The ARV drugs may have therapeutic benefit for the treatment of non-HIV retroviral disease, i.e., AZT for HTLV-1-related conditions and 3TC for hepatitis B. The fields of immunology and cytokine research have been greatly stimulated by efforts to better understand HIV-related immune deficiency and the body's effort to control HIV. The observation that some patients can survive HIV infection long term, probably due mostly to their immune response to HIV, has increased hope that better knowledge about the immune system can translate into therapeutic benefit.

Efforts directed at understanding, preventing, and treating the many HIV-related opportunistic infections have yielded many advances directly applicable to other disease processes. New infectious agents have been identified (herpes type 6, Kaposi sarcoma-associated herpes, *Rochalimaea* species—the agents of cat-scratch fever and bacillary angiomatosis—and *Rhodococcus equi*). The prevention and treatment of AIDS-related infections has benefited the fields of transplantation and oncology. For example, cytomegalovirus is a major cause of morbidity and mortality in transplant patients, yet there was no effective therapy prior to the AIDS epidemic (now ganciclovir and foscarnet are licensed, and more drugs are on the way). Studies of the distribution of AIDS-related infections have had important implications for our understanding of which human populations are at risk for certain infections, i.e.,

Table 8

*HIV epidemiologic and behavior studies***Minnesota Department of Health**

HIV surveillance and seroprevalence studies.

Contact: Rich Danila, Ph.D., M.P.H., 612/623-5414

Program in Human Sexuality, Department of Family Practice & Community Health, University of Minnesota Medical School

Psychosocial HIV research focused on effects of intervention, safer sex behavior, and mental health concerns of HIV-infected people.

Contact: Simon Rosser, Ph.D., 612/625-1500

University of Minnesota Department of Epidemiology

Tuberculosis and tuberculosis infections associated with HIV.

Contact: Alan Lifson, M.D., M.P.H., 612/625-2167

HIV Programs, St. Paul-Ramsey Medical Center

Risks to health care workers.

Contact: Keith Henry, M.D., 612/221-1280

Community Program for Clinical Research on AIDS (CPCRA)

National statistical center for community-based research sites.

Contact: Jim Neaton, Ph.D., 612/626-9040

Cryptosporidium, *Mycobacterium avium-intracellulare*, and tuberculosis.

It is clear that HIV/AIDS research has already had a significant impact on medical practice and that researchers in Minnesota are making valuable contributions to knowledge about HIV in many areas. Since HIV infection is an expensive condition to treat (an estimated \$110,000 per patient¹⁷), much work needs to be done to determine how to best treat HIV cost-effectively. Because it is difficult for most clinicians to keep up with the latest HIV developments and treatments, we recommend physicians read one of the many excellent HIV-related newsletters (see Table 9) and contact an HIV clinical researcher. In Minnesota, the *Minnesota Positive* newsletter, published bimonthly by the HIV Program at St. Paul-Ramsey Medical Center, is a good source of HIV information, including resources and active clinical studies. The best time to consider HIV-related clinical studies for a patient is soon after a physician has first seen the patient and before any therapy is started. Physicians who are following HIV-infected patients are encouraged to call the St. Paul-Ramsey Medical Center HIV/AIDS Programs at 612/221-1280 to speak to a physician or study nurse about suitable studies being conducted throughout the state. Since many studies require patients to be naive to any previous therapy, it is important to discuss available studies very soon after the patient is first identified as HIV infected. Such collaboration is essential to the success of HIV research in Minnesota, and to optimal medical care of HIV-infected patients in our state.

MM

Keith Henry is director of the HIV/AIDS Clinic and Programs at Health-Partners St. Paul-Ramsey Medical Center and an associate professor with the University of Minnesota Medical School. He also serves as medical director for the St. Paul Department of Health's HIV and Sexually Transmitted Disease Clinic and is involved with the AIDS Clinical Trials Group sponsored by the National Institute of Allergy and Infec-

Table 9

Recommended HIV/AIDS newsletters

Name	Focus	Phone #
<i>Minnesota Positive</i>	General HIV information; research update/events; resources	612/221-1280
<i>Positively Aware</i> (inserted in <i>Minnesota Positive</i>)	General HIV information	612/221-1280
<i>AIDS/HIV Treatment Directory</i>	National resource for research protocols; listing of investigational drugs	212/682-7440
<i>AIDS Treatment News</i>	Reports on experimental and standard treatments	415/255-0588
<i>AIDS Clinical Care</i>	General HIV information; research update	800/843-6356
<i>Beta</i>	Reports on experimental treatments; research update	800/959-1059
<i>Gay Men's Health Crisis Treatment Issues</i>	Newsletter of experimental AIDS therapies	212/337-1950

tious Diseases. Holly Melroe and Ray Nelson are registered nurses with the HIV/AIDS Programs at St. Paul-Ramsey Medical Center.

REFERENCES

1. Daar ES, Moudgil T, Meyer R, Ho DD. Transient high levels of viremia in patients with primary human immunodeficiency virus type 1 infection. *N Engl J Med* 1991;324:961-4.
2. Embretson J, Zupancic M, Ribas JL, et al. Massive covert infection of helper T lymphocytes and macrophages by HIV during the incubation period of AIDS. *Nature* 1993;362:359-62.
3. Pantaleo G, Graziosi C, Demarest JF, et al. HIV infection is active and progressive in lymphoid tissue during the clinically latent stage of disease. *Nature* 1993;362:355-8.
4. Piatak M Jr., Saag MS, Yang LC, et al. High levels of HIV-1 in plasma during all stages of infection determined by competitive PCR. *Science* 1993;295:1749-54.
5. Cao Y, Ho DD, Todd J, et al. Clinical evaluation of branched DNA signal amplification for quantifying HIV type 1 in human plasma. *AIDS Res Hum Retroviruses* 1995;11:353-61.
6. Wei X, Ghosh SK, Taylor ME, et al. Viral dynamics in human immunodeficiency virus type 1 infection. *Nature* 1995;373:117-22.
7. Ho DD, Neumann AU, Perelson AS, et al. Rapid turnover of plasma virions and CD4 lymphocytes in HIV-1 infection. *Nature* 1995;373:123-6.
8. Coffin JM. HIV population dynamics in vivo: implications for genetic variation, pathogenesis, and therapy. *Science* 1995; 267:483-9.
9. Navia MA, Fitzgerald PM, McKeever BM, et al. Three-dimensional structure of aspartyl protease from human immunodeficiency virus HIV-1. *Nature* 1989;337: 615-20.
10. Larder BA, Kemp SD, Harrigan R. Potential mechanism for sustained antiretroviral efficacy of AZT-3TC combination therapy. *Science* 1995;269:696-700.
11. Minnesota Department of Health AIDS Epidemiology Unit. Opportunistic/AIDS indicator diseases diagnosed in Minnesota AIDS patients at time of AIDS diagnosis and subsequent to AIDS diagnosis, 1982-94. Minneapolis: Minnesota Department of Health, 1995.
12. Price RW, Worley JM. Management of neurologic complications of HIV-1 infection and AIDS. In: Sande MA, Volberding PA, eds. *The medical management of AIDS*. 4th ed. Philadelphia: W.B. Saunders Co., 1995:261-88.
13. Macallan DC, Noble C, Baldwin C, et al. Energy expenditure and wasting in human immunodeficiency virus infection. *N Engl J Med* 1995;333:83-8.
14. Grunfeld C. What causes wasting in AIDS? [Editorial]. *N Engl J Med* 1995; 333:123-4.
15. Lifson AR. Preventing AIDS: have we lost our way? [Editorial]. *Lancet* 1995; 346:262.
16. Henry K. Setting AIDS priorities: the need for a closer alliance of public health and clinical approaches toward the control of AIDS. *Am J Public Health* 1988; 78:1210-2.
17. Hellinger FJ. The lifetime cost of treating a person with HIV. *JAMA* 1993;270:474-8.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. —and that's not a line, it's a promise.

Opportunities now available for board-certified/board-eligible physicians:

- Family Practice
- General Surgery
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- Urgent Care



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
612-885-6224
1-800-842-6469



HIV Infection in Women and Children

Kay E. Schwabke, M.D., M.P.H., and Laura G. Hoyt, M.D.

ABSTRACT

AIDS is increasing more rapidly among women than men and has become the fourth-leading cause of death for women between the ages of 25 and 44 years in the United States. This changing epidemiological trend accounts for the increase in pediatric cases of HIV infection. This article summarizes features of the HIV epidemic, with a special focus on women and children. We review epidemiology, clinical characteristics, vertical transmission, treatment, and prevention opportunities.

EPIDEMIOLOGY

Despite stabilizing numbers of newly reported AIDS cases in the United States, AIDS is increasing among two groups: women and infants born to HIV-infected women.¹ The number of women with AIDS in the United States increased from 534 (7% of total cases) in 1985 to 14,081 (18% of total cases) in 1994.² AIDS cases among women reported in 1994 represented 25% of those reported during the entire epidemic. Women of color continue to be over-represented, with 77% of cases reported among African-American and Hispanic women.² Although in the past AIDS in women was primarily associated with drug injection, heterosexual transmission is now the predominant mode of transmission in this population.³ AIDS is increasing faster among women than men and is now the fourth-leading cause of death among women aged 25 to 44 years. Some researchers have estimated that it will become the second-leading cause of death by the year 2000.

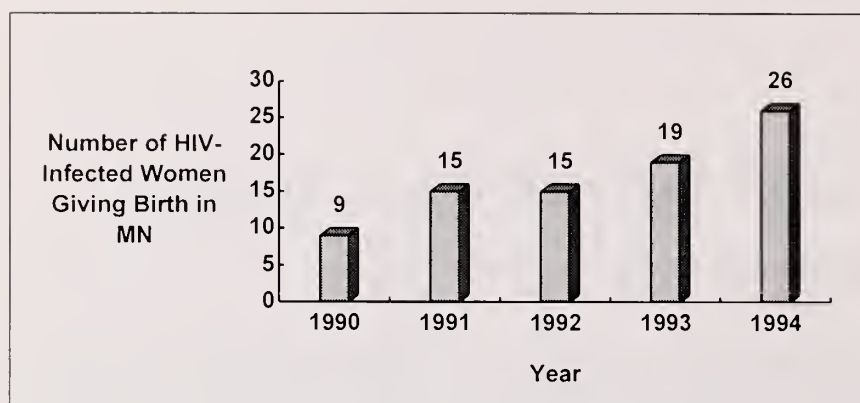
Through December 1994, 6,209 children had been reported with AIDS in the United States; 89% acquired their infection perinatally (born to an HIV-infected mother).⁴ Using the data from the HIV Survey of Childbearing Women, an estimated 7,000 HIV-infected women delivered infants in 1993. Approximately 1,000 to 2,000 infants were perinatally infected in the United States in 1993. These numbers have continued to increase each year throughout the epidemic.

HIV infection is a real and emerging problem for women and children in Minnesota. According to Dorothy Reier at the Minnesota Department of Health (MDH), 454 women with HIV/AIDS had been reported to MDH by March 1995. In 1994, the

male-to-female ratio of newly reported HIV cases in Minnesota was approximately 4-to-1, a drastic change from the original 15-to-1 male-to-female ratio reported nearly one decade ago. According to Richard Danila of MDH, a total of 37 children with HIV/AIDS had been reported in Minnesota through March 1995, 29 (78%) of whom were still alive at that time. The state data from the HIV Survey of Childbearing Women have shown steady increases in the numbers of HIV-infected women giving birth in Minnesota (see the figure). These data can also be used to project the number of infected children expected to be born each year. Unfortunately, these data show that only approximately 40% of the projected number of HIV-perinatally infected children born in Minnesota since 1992 have been diagnosed.

HIV-INFECTED WOMEN

Natural history studies of HIV-infected women are limited. Recently, two large, multicenter, observational cohorts have been developed that include HIV-infected women. The purpose of these studies, funded by the Centers for Disease Control and Prevention and the National Institutes of Health, is to describe the natural history of HIV infection in women, including virologic, clinical, immunologic, endocrine, and social outcomes. The Women's Interagency HIV Study (WIHS) will eventually enroll 2,000 HIV-seropositive women and 500 HIV-seronegative women. The HIV Epidemiology Research Study (HERS) will enroll 800 HIV-seropositive women and 400 "at-risk" HIV-seronegative women. Both studies should significantly enhance our understanding of HIV infection in women.



Figure—Summary of data from the Minnesota HIV Survey of Childbearing Women

Table 1

Pediatric HIV infection: case examples of a "rapid" and "slow" progressor

Rapid progressor

"Tamika" is an example of a child with rapid progression. Tamika appeared to her family to be growing and developing normally through the first 6 months of life. At that point, she was rolling over and seemed to be starting to sit. Her growth was at the 25th percentile. Over the next three months, her development regressed and she progressively became a poor feeder with eventual weight loss. When she was diagnosed with AIDS at 9 months of age, she had no head or trunk control, was less than the 5th percentile for weight, and was constantly irritable. She was severely immunocompromised. Within weeks of starting antiretroviral therapy, she was smiling, regaining trunk and head control, and had stabilized her weight. She continued with slow developmental and growth improvements and could walk by the time she was 2 years old. She is now nearly 4 years old and doing well clinically.

Slow progressor

"Lisa" is an example of a child with slow progression. Lisa presented at age 11 to her community hospital with fever, cough, tachypnea, and hypoxia. *Streptococcus pneumoniae* grew from her blood culture; her fever resolved with appropriate antibiotic therapy, but her tachypnea and hypoxia did not. She was diagnosed with perinatally acquired HIV infection and with lymphoid interstitial pneumonitis by lung biopsy. With therapy, she improved and returned to her usual activities as a straight-A student and athlete. She continued to do well despite worsening immunosuppression until she developed multiple complications at the age of 14½ years; she died at age 15.

Recent studies that have investigated the progression of HIV infection to AIDS have not supported the notion that survival time is significantly different for women and men.⁵⁻⁷ In 1994, the Community Programs for Clinical Research on AIDS (CPCRA) published data about dis-

ease progression and mortality among men and women at 17 CPCRA sites.⁸ Although no differences in disease progression were found, women were one-third more likely than men to experience death as the first clinical event after enrollment. Reasons for the poorer survival in women partic-

ipating in this study are unclear. These differences may reflect differences in access to care and treatment, poverty, complications associated with substance abuse, and/or differences in social support. The incidence of certain opportunistic diseases has varied by gender. Melnick et. al.⁸ report an increased risk for bacterial pneumonia among HIV-infected women and a reduced risk for Kaposi sarcoma and oral leukoplakia. In addition, as compared with HIV-seronegative women, HIV-seropositive women often experience recurrent vaginal candidiasis and have an increased prevalence of human papillomavirus infection and cervical dysplasia.

Factors such as domestic violence, mental illness, substance abuse, isolation, poverty, and lack of child care and transportation often make it difficult for HIV-infected women to access health care and other necessary services. A multidisciplinary team approach is often helpful when providing medical care in the context of complex social issues.

VERTICAL TRANSMISSION

Vertical transmission studies have suggested a maternal-infant transmission rate of 15% to 40%.⁹ The European Collaborative Study prospectively evaluated 701 pregnant HIV-infected women and their 721 children.¹⁰ The vertical transmission rate was 15%.

Although the relative frequency of antepartum and peripartum infection is not known, indirect evidence suggests that a substantial proportion of infants acquire infection during the peripartum period. Peripartum transmission might occur by several mechanisms.¹¹ First, transmission might occur by direct contact of the infant with infected genital secretions and blood during passage through the birth canal. Second, transmission might occur via an ascending infection from the vagina or cervix to the amniotic fluid and fetal membranes. Indeed, studies have reported a positive association between vertical transmission and duration of membrane rupture.¹¹ Finally, transmission might occur through maternal-fetal microtransfusions,

providing direct contact of circulating maternal virus with the infant's circulation. Several small studies have demonstrated a positive association between vertical transmission and high viral load.^{12,13} Additional risk factors associated with vertical transmission have included maternal p24 antigenemia, low maternal CD4 count, low infant birthweight, breastfeeding, and a variety of invasive procedures used during delivery.

Results from the AIDS Clinical Trials Group (ACTG) protocol 076 have demonstrated that zidovudine (ZDV) use during pregnancy significantly decreases vertical transmission of HIV.¹⁴ The rate of vertical transmission was 25.5% in the placebo group and 8.3% in the ZDV-treated group. Mothers in the treatment group received oral ZDV (no sooner than 14 weeks of gestation) prior to delivery and intravenous ZDV during delivery; their infants then received oral ZDV for six weeks. It remains unclear which component of the intervention contributed to the outcome. However, recent retrospective analysis of an observational cohort study involving 321 women in New York City has suggested that antenatal ZDV treatment alone may substantially reduce vertical transmission.¹⁵

The results of ACTG 076 have fueled many discussions regarding voluntary versus mandatory HIV testing for pregnant women.¹⁶ The CDC recently published guidelines that specifically address this issue. The CDC recommends that "all pregnant women [be] routinely counseled and encouraged to be tested for HIV infection" and that HIV testing of pregnant women "should be voluntary." Routine HIV pretest counseling should include information about confidential testing sites. Voluntary testing is favored for many reasons, including the high acceptance rates (often higher than 90%) for testing in voluntary settings and the concern that mandatory testing will discourage women from receiving prenatal care.

HIV-INFECTED CHILDREN

HIV infection in infants and children differs from that seen in adolescents

Table 2

*Local and national studies for HIV-infected women**

Zidovudine (ZDV) disposition in pregnant HIV-infected women

An evaluation of ZDV pharmacokinetics in pregnant, HIV-infected women

Location: Multiple centers, including Minnesota

Contact: Laurie Felland, 612/221-1280

AIDS Clinical Trials Group (ACTG) Studies—available in Minnesota

List available through *Minnesota Positive* publication, 612/221-1280

ACTG Studies—not available in Minnesota

ACTG 185—A randomized, double-blind controlled study of the use of HIVIG for the prevention of maternal-fetal HIV transmission in pregnant women receiving zidovudine

ACTG 200—A randomized trial of topical vaginal fluorouracil maintenance therapy versus observation after standard treatment for high-grade cervical dysplasia in HIV-infected women

ACTG 249—An evaluation of ddI in HIV-1-infected pregnant women

ACTG 250—A study of the safety and pharmacokinetics of nevirapine in pregnant women and neonates

ACTG 255—A study of perinatal transmission of zidovudine-resistant HIV among pregnant women treated with zidovudine

Corning Besselaar Clinical Research Unit

Study 8096—An evaluation of oral ganciclovir (Cytovene) pharmacokinetics in HIV- and CMV-seropositive women versus men

Location: Madison, Wisconsin

Contact: Corning Besselaar staff, 608/283-5688 or 800/732-2528

*Additional studies involving HIV-infected women and men are summarized in *Minnesota Positive*, 612/221-1280.

and adults in several important ways. These include the difficulty of diagnosis in infancy, the different clinical presentations, and several important differences in treatment recommendations. Although only 15% to 30% of infants born to HIV-infected women will themselves be HIV infected, virtually all these infants are born with transplacentally acquired maternal anti-HIV antibody. This antibody usually disappears by 9 to 12 months of age, but it has been shown to persist for as long as 18 months in the child's circulation. Thus, the standard HIV antibody tests (ELISA and Western Blot or IFA) cannot be used to diagnose HIV infection before 18 months of age. Lack of antibody in

this age group does not definitively rule out infection, because infected children may not yet be producing sufficient antibodies on their own. Therefore, tests that detect the presence of HIV (e.g., HIV culture, HIV PCR, p24 antigen) in the blood are used for diagnosis. Prospective studies have led to the recommendation that children born to HIV-infected mothers be tested with HIV culture and/or PCR at 1, 3, and 6 months of age. If these tests are all negative, and the infant is otherwise well, they predict with greater than 95% certainty that the infant is not HIV infected. During this period of intensive testing, it is important that the child's immune system be monitored by fol-

lowing the T and B lymphocytes and the clinical examination. Following this testing, the infant can be followed every three months until 18 months old.¹⁷

The clinical presentation of HIV disease in children is quite variable. Approximately one-third of children fit into the category of "rapid progressors." These children demonstrate the old stereotype of what HIV disease "looks like" in children. They present in the first year of life and commonly have severe failure to thrive and progressive encephalopathy. *Pneumocystis carinii* pneumonia (PCP) is a frequent and serious opportunistic infection in this group of children.

The remaining two-thirds of children with HIV disease present as "slow progressors." These children do not present with clinical illness until they are 2 to 14 years old. They generally have mild or no abnormalities in growth and development and seem "normal" on gross appearance. They commonly have generalized lymphadenopathy, lymphoid interstitial pneumonitis, and recurrent nonserious bacterial and fungal infections. Case examples of a rapid and slow progressor are provided in Table 1.

It is important to recognize that many HIV-perinatally infected children are now living well into their teens (at least 16 years old). Those who have been diagnosed earlier in childhood have the best chance of maintaining good or only moderately suppressed immune systems; those not diagnosed until late childhood or adolescence generally have severely depleted immune systems at the time of diagnosis and, therefore, have a worse prognosis.

This year, the CDC published revised guidelines for prophylaxis against PCP for children infected with or perinatally exposed to HIV.¹⁸ Because of the amount of time it takes to make an HIV diagnosis, and because the highest risk for PCP occurs between 3 and 6 months of age for HIV-infected children, it is now recommended that all infants exposed to HIV perinatally be given PCP prophylaxis starting at 4 to 6 weeks of life. This prophylaxis continues

until at least 1 year of life unless the child has been shown not to be HIV infected.

PROGRAMS AND RESEARCH:

LOCAL EFFORTS

Programs and research opportunities are available for HIV-infected women and children in Minnesota. A summary of research projects is provided in Table 2. Investigators and other individuals interested in studies for HIV-infected women or children should contact Kay Schwebke, M.D., 612/221-1280, or Laura Hoyt, M.D., 612/624-1112. A list of support groups in Minnesota is provided in the *Minnesota Positive* newsletter, 612/221-1280. In addition, information about child care, foster care, and respite care is available through the Minnesota AIDS Project AIDSline, 612/373-2437 or 800/248-2437.

SUMMARY

As the incidence of HIV infection has increased among women, growing numbers of children have become infected through vertical transmission. HIV infection has rapidly become a major cause of illness and death among women and children. As the epidemic changes, we must learn to recognize the characteristic signs and symptoms that suggest a diagnosis of HIV infection. More important, the time has come to recognize women and children as populations at risk. This recognition is absolutely imperative as we strengthen prevention efforts and improve our early diagnosis of HIV infection.

Kay Schwebke is a staff physician with the HIV/AIDS Clinic and Programs at HealthPartners St. Paul-Ramsey Medical Center and with the Internal Medicine and Infectious Diseases departments at River Valley Clinic (Allina Health System) in Northfield, Minnesota. Laura Hoyt is an assistant professor of pediatrics at the University of Minnesota, Department of Medicine, Division of Infectious Diseases, and a staff physician with the Infectious Diseases Department at Children's Health Care-St. Paul.

REFERENCES

- Centers for Disease Control and Prevention. Update: acquired immunodeficiency syndrome—United States, 1994. MMWR 1995;44:64-7.
- Centers for Disease Control and Prevention. Update: AIDS among women—United States, 1994. MMWR 1995; 44:81-4.
- Centers for Disease Control and Prevention. Heterosexually acquired AIDS—United States, 1993. MMWR 1994; 43:155-60.
- Centers for Disease Control and Prevention. HIV/AIDS Surveillance Report 1994;6(2):13.
- Lemp GF, Hirozawa AM, Cohen JB, et al. Survival for women and men with AIDS. J Infect Dis 1992;166:74-9.
- Farizo KM, Buehler JW, Chamberland ME, et al. Spectrum of disease in persons with human immunodeficiency virus infection in the United States. JAMA 1992;267:1798-1805.
- Chang HH, Morse DL, Noonan C, et al. Survival and mortality patterns of an acquired immunodeficiency syndrome (AIDS) cohort in New York State. Am J Epidemiol 1993;138:341-9.
- Melnick SL, Sherer R, Louis TA, et al. Survival and disease progression according to gender of patients with HIV infection. JAMA 1994;272:1915-21.
- Vermund SH, Galbraith MA, Ebner SC, Sheon AR, Kaslow RA. Human immunodeficiency virus/acquired immunodeficiency syndrome in pregnant women. Ann Epidemiol 1992;2:773-803.
- European Collaborative Study: risk factors for mother-to-child transmission of HIV-1. Lancet 1992;339:12.
- Mofenson LM. A critical review of studies evaluating the relationship of mode of delivery to perinatal transmission of human immunodeficiency virus. Pediatr Infect Dis J 1995;14:169-77.
- Peckham C, Gibb D. Mother-to-child transmission of the human immunodeficiency virus. N Engl J Med 1995; 333:298-302.
- Weiser B, Fang G, Tropper P, et al. QC-PCR quantitation of HIV plasma RNA level during pregnancy: relationship to mother-to-child transmission and antiviral therapy. In: Abstracts of the HIV Infection in Women Conference: setting a new agenda. Richmond, Virginia: Philadelphia Sciences Group, 1995:S20.
- Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. N Engl J Med 1994;331:1173-80.
- Matheson PB, Abrams EJ, Thomas PA, et al. Efficacy of antenatal zidovudine in

reducing perinatal transmission of human immunodeficiency virus type 1. *J Infect Dis* 1995;172:353-8.

16. Centers for Disease Control and Prevention. U.S. Public Health Service recommendations for human immunodeficiency virus counseling and voluntary testing for pregnant women. *MMWR* 1995;44(No. RR-7):1-15.

17. Centers for Disease Control and Prevention. 1994 revised classification system for human immunodeficiency virus infection in children less than 13 years of age. *MMWR* 1994;43(No. RR-12):1-10.

18. Centers for Disease Control and Prevention. 1995 revised guidelines for prophylaxis against *Pneumocystis carinii* pneumonia for children infected with or perinatally exposed to human immunodeficiency virus. *MMWR* 1995;44(No. RR-4):1-11.

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

**Family Practice
OB/GYN
Urgent Care
Internal Medicine**

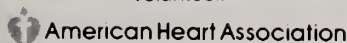
Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



**BE A GOOD
NEIGHBOR**

Volunteer.



North Central Medical Conference Presents

CHINA - YANGTZE RIVER CRUISE - HONG KONG

March 20-April 4, 1996 (16 days) \$2,999.00 (Plus Taxes)

March 14-26, 1996 (12 days) \$2,559.00 (Plus Taxes)

per person, double occupancy

The resplendent grandeur of China's ancient dynasties beckons you across 3,000 years of history, art, and struggle for perfection. Cruise the Yangtze River through the most spectacular stretch of river scenery. Visit Hong Kong, one of the most exciting places on earth.



BEST OF THE ORIENT

March 17-27, 1996 (11 days)

\$2,349.00 (Plus Taxes)

per person, double occupancy

In Bangkok discover the treasures of the Kingdom, a land of unsurpassed scenic beauty. Singapore, the most surprising island on earth, a multi-cultural Mecca with Chinese, Malay, and Indian influences, and cosmopolitan, energetic Hong Kong.

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.

For additional information and a color brochure contact.

GLOBAL HOLIDAYS

9725 Garfield Avenue South, Minneapolis, MN 55420-4240 (612) 948-8322 Toll Free: 1-800-842-9023

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.

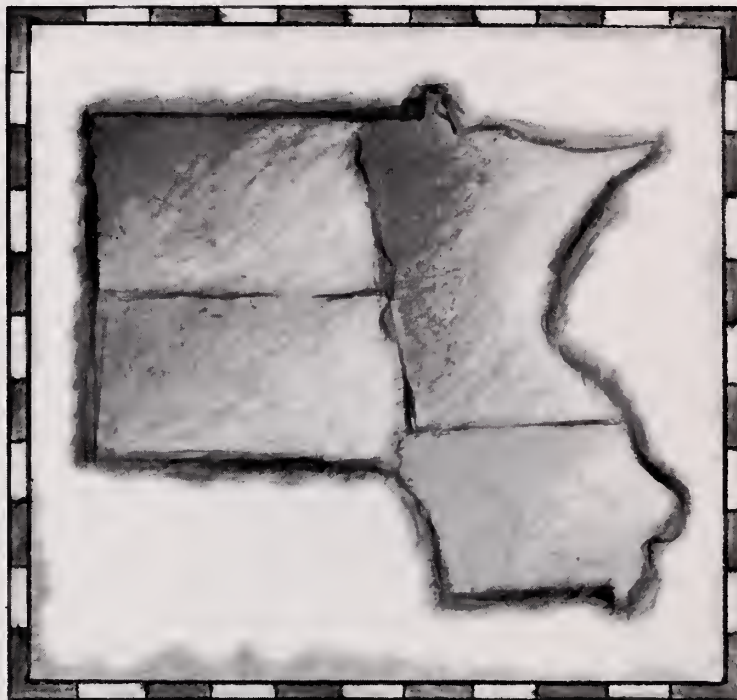


To The Nth Degree[®]

Minneapolis 667-0705

©1995 Norwest Bank Minnesota N.A.
Member FDIC

MIDWEST MEDICAL INSURANCE COMPANY



PROTECTING PHYSICIANS IN THE UPPER MIDWEST

The Midwest Medical Insurance Company was created by and for the benefit of its physician policyholders in Minnesota, Iowa, North Dakota and South Dakota.

MMIC meets the professional liability insurance needs of over 5,000 upper midwest physicians. Its strength and stability are well evidenced by an A (EXCELLENT) rating from A.M. Best.

With assets exceeding \$200 million and surplus of \$65 million to assure that policyholder liabilities will be met, MMIC is able to focus on providing efficient service and attractive premiums.

Physician direction and medical input support the efforts of the professional staff. The service provided by MMIC claims, risk management and underwriting personnel is unparalleled. Coverage enhancements have come steadily since MMIC began in 1980.

MMIC has experience serving large and small medical practices and can provide you with well-designed coverage proposals with competitive rates.

For a quotation or other information about MMIC, please call us at 612-922-5445 or 1-800-328-5532.



MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S., Suite 245, Minneapolis, MN 55435-1891

Needlestick/Sharps Injuries and HIV Exposure Among Health Care Workers

National Estimates Based on a Survey of U.S. Hospitals

Keith Henry, M.D., and Scott Campbell, R.N., M.S.P.H.

ABSTRACT

Exposure to HIV in the workplace is a major concern for health care workers. The greatest risk for bloodborne pathogen transmission is associated with percutaneous injuries involving hollow-bore needles contaminated with potent blood. Limited data are available about how many sharps injuries (SIs) and needlesticks (NSs) occur in the United States, with estimates ranging from 100,000 to 1 million injuries per year. We conducted a survey of 100 infection control practitioners located at randomly selected U.S. hospitals to assess the number of SIs or NSs occurring during 1990; 65 (65%) responded. The mean number of NS/SIs reported was 45, with a mean of 1.1 known HIV-related NS/SIs. The underreporting rate was estimated to be 18.5%. Assuming that the hospitals provided exact numbers of injuries and were representative of the approximately 5,100 U.S. hospitals, then about 252,000 NS/SIs were reported in U.S. hospitals in 1990 (95% CI=193,000-312,000). If the underreporting rate was 33% to 66%, then the point estimate for the total number of NS/SIs ranges from 378,000 to 756,000. Similar extrapolation involving the reported number of NS/SIs contaminated with blood from an HIV-infected patient yields an estimate of 5,610 exposures in 1990 (95% CI=1,300-8,300). The number of U.S. hospital workers sustaining NS/SIs with potential exposure to HIV appears to be considerable. Efforts to reduce the risk of bloodborne pathogen transmission from NS/SIs are warranted.

The HIV/AIDS epidemic has heightened concern among health care workers about work-related exposure to bloodborne pathogens. In an effort to better protect health care workers, the Centers for Disease Control and Prevention (CDC) has formulated recommendations describing universal precautions that prevent the health care worker from coming in direct contact with patient body fluids potentially contaminated with bloodborne pathogens.¹⁻³

The Occupational Safety and Health Administration (OSHA) has developed additional regulations pertaining to health care worker safety that essentially require health care facilities to comply with universal precautions.⁴ Adoption of and compliance with universal precautions is costly and has yet to be convincingly demonstrated to significantly decrease exposures.⁵⁻⁹

Numerous studies have examined the factors associated with HIV transmission to health care workers after an exposure.^{10,11} A high percentage of documented HIV seroconversions have occurred after a percutaneous injury. More specifically, most health care workers' HIV infections occurred after injury with a hollow-bore needle contaminated with blood from a patient with HIV.¹² Thus, the number of needlestick injuries occurring in the health care setting is the most significant variable in bloodborne pathogen transmission and should be the benchmark for evaluating the impact of mandated universal precautions programs on bloodborne pathogen transmission.

Despite their importance in evaluating overall risk in the health care setting, surprisingly little data are available about how many needlestick injuries/sharps injuries occur in

the United States. Current estimates from experts range from 100,000 to 1 million NS/SIs per year. Lack of better data on this topic makes it difficult to evaluate the impact of universal precautions or engineered safety devices on injuries and hard to compare the costs and benefits of these strategies. We conducted a study of U.S. hospitals to obtain a more accurate estimate of the number of NS/SIs occurring in these settings.

METHODS

In March 1991, we sent a seven-page, 56-item survey to the infection control practitioners at 100 hospitals randomly selected from the American Hospital Association's "AHA Guide 1988."¹³ We chose the hospital infection control practitioner as the employee most likely to have access to information about NS/SIs. We assigned each hospital a code number attached to the survey. We sent nonresponding hospitals second or third surveys three weeks and six weeks after the initial mailing.

The first section of the survey collected hospital demographic data, such as the average inpatient census, average HIV/AIDS inpatient census, etc. The second section of the survey asked for information regarding needlestick and other sharps injuries reported to the infection control practitioner during calendar year 1990. One item requested the exact number of injuries reported during 1990; if this number was not known, the respondent was asked to estimate the number of injuries. If the exact or estimated number was not known, the respondents were asked to indicate this on the survey. A similar item requested the exact or estimated number of reported injuries that involved source patients known to be HIV positive. Finally, the survey asked

respondents to estimate what percentage of NS/SIs were not reported within their hospital. We performed descriptive and inferential statistical analysis using the Statview statistical program.¹⁴ Significance was set as $\alpha < 0.05$.

RESULTS

DEMOGRAPHICS

Sixty-five hospitals responded (65%). About 60% of the hospitals served metropolitan areas of between 500,000 and 4 million people, and those hospitals were generally affiliated with a local medical school.

NEEDLESTICK/SHARPS INJURY INCIDENCE RATES

The mean number of NS/SIs reported at the 62 hospitals that provided exact or estimated numbers was 45 NS/SIs in 1990. The difference in mean scores between hospitals providing exact numbers vs. those giving estimates was not significant. Fifty-six hospitals provided an exact or estimated number of reported NS/SIs for which the source patient was known to be HIV positive; the mean was 1.1 HIV-related NS/SIs in 1990. Again, the difference in mean scores between those hospitals providing exact and estimated numbers was not significant.

ESTIMATED REPORTING RATES

The respondents estimated that 18.5% of all NS/SIs that occur in their hospitals are not reported; they also estimated that only 1.4% of NS/SIs involving a source patient known to be HIV infected were not reported.

DATA EXTRAPOLATION

If the sample of responding hospitals is representative of the approximately 5,100 U.S. acute-care hospitals, then the rate of 45 NS/SIs reported per hospital would yield a figure of 229,500 NS/SIs in U.S. hospitals in 1990 (95% confidence interval=180,407-278,266). If the underreporting rate of 18.5% is assumed accurate, then the number of NS/SIs occurring annually in U.S. hospitals is estimated to be 281,595 (229,500 divided by 0.815). The 95% confi-

dence interval for total number of NS/SIs would be adjusted to 221,358-341,431. If the level of underreporting was greater than the respondents estimated (in the range of 33% to 66% not reported) as suggested by some earlier studies,¹⁵⁻¹⁷ then the estimate for the total number of NS/SIs in the United States would be 344,250 to 688,500.

Similar extrapolation of the exact and estimated HIV-related NS/SIs data (1.1 per hospital/year) yields an estimated 5,610 NS/SIs involving source patients known to be HIV-infected in 1990 (95% CI=2,581-8,711). Since the respondents believe most of those injuries are reported, no major adjustment needs to be made for underreporting. Assuming that 50% of NS/SIs involve hollow-bore needles, and the HIV-seroconversion rate for such exposure is 0.3%,¹⁸ then approximately eight HIV seroconversions would be predicted among U.S. hospital personnel in 1990 from needlestick exposure (95% CI=4-13). The table provides a summary of the national estimates based on our survey data.

DISCUSSION

The actual number of NS/SIs occurring among health care workers is unknown. Estimates quoted in the literature vary widely and are based on little data. We believe our data provide a reasonable estimate (281,595) of the number of NS/SIs occurring in U.S. hospitals in 1990. Since NS/SIs are the major route by which health care workers become infected with bloodborne pathogens, the total number of NS/SIs is an index for risk and is a major target for any worker safety program.

These results must be interpreted with caution. Although the hospitals were chosen at random, they may not be representative of U.S. hospitals overall. We selected the infection control practitioner as the person most likely to gather data on injuries to health care workers. At some sites, injuries may be reported to employee health services or the infectious diseases section. Thus, the method and completeness of the data collection at each hospital probably varies widely. We had no control over

Table

National estimates of NS/SI and NS-related HIV transmissions—1990

Assumption: the responding hospitals were representative of the 5,100 U.S. hospitals.

Sixty-two* responded that a mean of 45 NS/SIs were reported in 1990 to the infection control practitioner. The ICPs estimated that 18.5% of NS/SIs were not reported.

In 1990 an estimated 252,000 NS/SIs were reported (95% CI=193,000-312,000).

If 18.5% underreporting, then number of NS/SIs=281,595 (95% CI=221,358-341,431).

If underreporting=33% to 66%, then the estimate for number of NS/SIs=344,250 to 688,500.

For HIV exposures, an estimated 5,610 NS/SIs occurred in 1990.

Assumption: 50% involved hollow-bore needles at 0.3% transmission rate per exposure.

In 1990, an estimated 8.4 HIV infections occurred among health care workers after NS/SI exposure.

*Surveys were sent to 100 hospitals; 65 responded.

these variables.

Our estimate of total injuries may be conservative since it does not include NS/SIs sustained in non-hospital-based settings, e.g., clinics, offices, nursing homes, private homes, and hospices.¹⁹ Also, our sample may not adequately represent U.S. hospitals that treat large numbers of HIV-infected patients.

Any consideration of the cost-effectiveness of interventions to prevent NS/SIs needs to take into account the rate of injury per procedure. Our survey provides numerator data for injuries involving NS/SIs. Underreporting complicates interpre-

tation of data based on reported injuries.¹⁵⁻¹⁷ Educational efforts over the last several years have probably increased reporting rates, which have traditionally been too low. These rates must be factored into any analysis of interventions designed to reduce injuries. Even less is known about denominator data relating to rates of injuries for different types of needle/sharps devices.

At our institution, a 435-bed public teaching hospital in the Twin Cities metropolitan area,* 112 blood-contaminated NSs were reported in 1991. We have attempted to determine how many hollow-bore needles are used in a calendar year. We estimate that 145,000 vacutainer needles were used and 26,000 butterfly needles. In addition, we estimate that 15,000 intravenous or arterial access devices were used during 1991. The estimate for the total for IV/arterial devices in 1991 is 186,145. Our estimate for the reported rate of injury with hollow-bore needles at our institution for 1991 is 112 per 186,145 uses (0.06% or 6 per 10,000 uses). In an observational study we conducted of phlebotomists at three teaching hospitals, we directly observed one NS out of 3,000 venopunctures (0.03%).²⁰

A cost-benefit analysis for the efficacy of new safety devices to prevent NS/SIs needs to consider the rate of injury and the cost of injury infection prevented. For the entire United States, if we applied our estimated number of NSs to our rate of injury per use, then we would calculate that 949,339,500 hollow-bore needles were used in U.S. hospitals in 1991. Our estimate of eight HIV transmissions in U.S. hospitals in 1991 caused by NS/SIs would suggest that one HIV transmission occurs per 118,667,480 uses. If the cost of converting to safety devices were 10 cents to \$1 per device, then the cost to prevent each HIV infection (assuming that the devices were 100% effective, which seems unlikely)

would be about \$11.8 million to \$118 million.

Although these are just gross estimates, the wide range and generally high cost help focus any discussion on optimal utilization of needle-safety devices. We believe that determining both national and local baseline rates for NS/SIs is an important component of this process. Review of health care worker occupationally acquired HIV cases reported to the CDC revealed that 84% of the 32 first-known seroconversions involved percutaneous exposures.²¹ It also is noteworthy that the total of 101 possible occupational HIV transmissions known to the CDC is similar to our estimates (8 cases per year reported $\times$ 13 to 14 years of the epidemic).²²

The general philosophy fundamental to both universal precautions recommendations and regulations developed by the Occupational Safety and Health Administration involves widely applied practices. In an ideal world, such an approach would provide the optimal level of protection to health care workers. However, practical issues such as cost and actual efficacy suggest that such a broad approach may not be desirable. Dennis Maki at the University of Wisconsin-Madison, an infection control authority, has estimated that universal precautions cost \$30 million per HIV infection prevented given the highly unlikely assumption that such practices were 100% effective (personal communication, September 1994). Many studies have shown in the pre-OSHA era that compliance with universal precautions in many settings was inadequate.^{6,9,23} Even in the period since the OSHA regulations have been in force, compliance among health care workers has been variable.²⁴⁻²⁶

We believe that a targeted approach to NS/SI prevention is likely to be more cost-effective. A model for this approach exists in the CDC HIV Sentinel Hospital Study, which determined HIV seroprevalence at hospitals throughout the United States.^{27,28} Since the HIV seroprevalence varied so widely, guidelines were developed to determine which hospitals should test patients for HIV.

Analysis of the data found that the AIDS index at each hospital (defined as number of new AIDS diagnoses per year reported from that hospital/number of discharges per year $\times$ 1,000) correlated closely with HIV seroprevalence. The recommendation was made to consider routine HIV testing of patients 15 to 54 years old at the 600 hospitals in the United States with an AIDS index of one or more. Since occupational risk for HIV transmission is related to background HIV seroprevalence, a targeted two-step approach would make sense. First, in areas with a high AIDS index (or bloodborne pathogen levels), needle-safety devices should be considered. Second, needle-safety devices should be considered when the patient is known to have a bloodborne pathogen (most notably HIV, hepatitis B, and hepatitis C).

Since resources are limited, and given that NSs cause the majority of significant exposures, we believe that occupational safety efforts should focus more on needle injury and less on other aspects of universal precautions and OSHA guidelines. Our estimates of costs per theoretical HIV transmission prevented indicate that universal use of needle-safety devices must be carefully assessed to avoid driving up health care costs without gaining any benefit. We are currently involved in a multisite project assessing baseline NS/SI rates related to phlebotomy and IV access followed by introduction of needle-safety devices to compare injury rates, which we hope will address some of these issues.

MM

Keith Henry is director of the HIV/AIDS Clinic and Programs at HealthPartners St. Paul-Ramsey Medical Center and an associate professor with the University of Minnesota Medical School. He also serves as medical director for the St. Paul Department of Health's HIV and Sexually Transmitted Disease Clinic and is involved with the AIDS Clinical Trials Group sponsored by the National Institute of Allergy and Infectious Diseases. Scott Campbell is a registered nurse with the Disease Intervention Unit, Minnesota Department of Health.

continued

*St. Paul-Ramsey Medical Center: 1991 admissions=13,206 with 261,269 clinic visits. HIV seroprevalence among laboratory specimens=1.85% in 1992.

REFERENCES

1. Centers for Disease Control and Prevention. Recommendations for prevention of HIV transmission in health-care settings. *MMWR* 1987;36(Suppl 2S):3-12.
2. Centers for Disease Control and Prevention. Update: universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings. *MMWR* 1988;37:377-82:387-8.
3. Centers for Disease Control and Prevention. Guidelines for prevention of transmission of human immunodeficiency virus and hepatitis B virus to health-care and public-safety workers. *MMWR* 1989;38(Suppl 56):3-37.
4. Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens: final rule. *Federal Register* 1991;56:64004-182.
5. Wagner M. High prices may hinder widespread use of needles with new safety features. *Mod Healthc* 1990; June 11:68.
6. Fahey B, Koziol D, Banks S, et al. Frequency of nonparenteral occupational exposures to blood and body fluids before and after universal precautions training. *Am J Med* 1991;90:145-53.
7. Courington KR, Patterson SL, Howard RJ. Universal precautions are not universally followed. *Arch Surg* 1991;126:93-6.
8. Lynch P, Jackson MM, Cummings J, et al. Rethinking the role of isolation practices in the prevention of nosocomial infections. *Ann Intern Med* 1987;107:243-6.
9. Wong ES, Stotka JL, Chinchilli VM, et al. Are universal precautions effective in reducing the number of occupational exposures among health care workers? *JAMA* 1991;265:1123-8.
10. McCray E. The Cooperative Needlestick Surveillance Group: occupational risk of the acquired immunodeficiency syndrome among health care workers. *N Engl J Med* 1986;314:1127-32.
11. Henderson DK, Fahey BJ, Willy M, et al. Risk for occupational transmission of human immunodeficiency virus type 1 (HIV-1) associated with clinical exposures: a prospective evaluation. *Ann Intern Med* 1990;113:740-6.
12. Marcus R. The Cooperative Needlestick Surveillance Group: surveillance of healthcare workers exposed to blood from patients infected with human immunodeficiency virus. *N Engl J Med* 1988;319:1118-23.
13. American Hospital Association. *AHA Guide* 1988. Chicago: American Hospital Association, 1988.
14. Kuzma J. Basic statistics for the health sciences. 1st ed. Palo Alto, California: Mayfield Publishing, 1984:91,138.
15. Hamory BH. Underreporting of needlestick injuries in a university hospital. *Am J Infect Control* 1983;11:174-7.
16. Mangione CM, Gerberding JL, Cummings ST. Occupational exposure to HIV: frequency and rates of underreporting of percutaneous and mucocutaneous exposures by medical housestaff. *Am J Med* 1991;90:85-90.
17. McGeer A, Simor AE, Low DE. Epidemiology of needlestick injuries in house officers. *J Infect Dis* 1990;162:961-4.
18. Gerberding JL. Limiting the risks of health care workers. In: Sande MA, Volberding PA, eds. *The medical management of AIDS*. 4th ed. Philadelphia: W.B. Saunders Co., 1995:89-101.
19. Thurn J, Crossley K. Needlestick injuries and needle disposal in Minnesota physicians' offices. *Am J Med* 1989;86:575-9.
20. McCabe K, Henry K, Campbell S, et al. Differences in universal precautions policies and practices among phlebotomists at three Minnesota teaching hospitals. Program and poster abstracts of the third international conference on AIDS. Amsterdam, 1992: Ab PoC4146.
21. Surveillance for occupationally acquired HIV infection. *MMWR* 1992;41:823-5.
22. Centers for Disease Control and Prevention. AIDS cases by year of diagnosis and definition category, diagnosed through June 1994, United States. In: *HIV/AIDS Surveillance Report* 1994;6:15.
23. Klein RS. Universal precautions for preventing occupational exposures to human immunodeficiency virus type 1. *Am J Med* 1991;90:141-4.
24. Henry K, Campbell S, Maki M. A comparison of observed and self-reported compliance with universal precautions among emergency department personnel at a Minnesota public teaching hospital: implications for assessing infection control programs. *Ann Emerg Med* 1992;21:940-6.
25. Henry K, Campbell S, Collier P, et al. Compliance with universal precautions and needle handling and disposal practices among emergency department staff at two community hospitals. *Am J Infect Control* 1994;22:129-37.
26. Hammond JS, Eckes JM, Gomez GA, et al. HIV, trauma, and infection control: universal precautions are universally ignored. *J Trauma* 1990;30:555-61.
27. St. Louis SE, Rauch JK, Petersen LR, et al. Seroprevalence rates of human immunodeficiency virus infection at sentinel hospitals in the United States. *N Engl J Med* 1990;323:213-8.
28. Janssen RS, St. Louis ME, Satten GA, et al. HIV infection among patients in U.S. acute care hospitals: strategies for the counseling and testing of hospital patients. *N Engl J Med* 1992;327:445-52.



**Hands
are not
for hitting.**

Domestic violence is preventable.

If someone is hurting you, call: 612/646-0994



Created by the Minnesota Coalition for Battered Women - 612/646-6177 V/TDD.  MMA

U.S. Prisoners' Access to Experimental HIV Therapies

Abigail Collins, Dana Baumgartner, B.S.N., M.S.H.S.A., Keith Henry, M.D.

ABSTRACT

Purpose: To examine Department of Corrections (DOC) policies prohibiting prisoner participation in research studies and to assess the variables associated with state policies and practices relating to access by inmates in U.S. prisons to HIV-related clinical studies and experimental therapies.

Methods: A telephone survey conducted in 1994-95 of DOC medical directors from 32 states throughout the United States to obtain information about state DOC policies and practices relating to HIV clinical studies.

Results: State policies governing prisoner participation in clinical trials and access to new therapies vary widely. States with high AIDS incidence rates, a large number of AIDS-related deaths in prison, and high concentrations of minorities in the correctional system were more likely to allow prisoners to enroll in clinical studies and to receive experimental medications. Overall, a relatively small number of prisoners in state prisons have enrolled in clinical studies. Participation of a prison representative on the board reviewing a clinical study was identified as an important factor in allowing prisoner participation in studies.

Conclusions: Barriers to prisoner participation in clinical studies are numerous but not insurmountable. Results from this study have led to efforts in Minnesota to revise current policy in order to permit prisoner participation in studies if appropriate guidelines are followed.

HIV/AIDS recently became the leading killer of adults between the ages of 25 and 44 in the United States.^{1,2} The epidemic has become an endemic infection increasingly targeting minorities, IV drug users, women, and the poor.^{3,4} Because these groups (excluding women) constitute the majority of the U.S. prison population, the impact of HIV/AIDS in the correctional system is amplified; in many systems, AIDS is the leading overall cause of inmate death.⁵⁻⁷ HIV research and treatment have made remarkable progress over the last decade in part because of the participation of large numbers of HIV-infected patients in research studies, which allow patients access to the newest therapies while addressing important treatment questions. The HIV Program at St. Paul-Ramsey Medical Center is not only active in numerous clinical studies (see related article, page 26), but also provides care for most of the HIV-infected prisoners in the state correctional system. However, the historic abuse of prisoners in research studies has prevented prisoners from participating in clinical drug trials during the last 20 years.⁸⁻¹⁰ St. Paul-Ramsey Medical Center has been unable to enroll prisoners in research studies because of a Minnesota Department of Corrections (DOC) policy prohibiting prisoner participation.

In this study, we examine the history of prisoner participation in research and the current policies and practices relating to prisoner access to HIV-related clinical studies in the United States. A primary goal was to develop a mechanism through which HIV-positive prisoners treated at St. Paul-Ramsey Medical Center could gain access to experimental therapies matching the spectrum of care offered to the general population.

U.S. HISTORY OF PRISONER PARTICIPATION IN RESEARCH

Unrestricted medical research on prisoners continued well into the 1970s in the United States, despite the regulations established shortly after World War II by the Nuremberg Code and Declaration of Helsinki governing the use of human subjects in research.^{8,9} Prisoners often were coerced into participating in research trials in exchange for such benefits as early parole. In the early 1970s, Jessica Mitford published "Kind and Usual Punishment" (Knopf, 1973), a book documenting these and numerous other abuses of U.S. prisoners. Around the same time, the infamous Tuskegee experiment was exposed to the public. Although it did not involve prisoners, the study did contribute to the growing awareness of potential abuse in research that uses human subjects.¹¹ The initial exclusion of prisoners from medical research trials was a protective measure taken in the anti-research climate of the late 1970s.^{8,9}

The U.S. Department of Health, Education, and Welfare (DHEW) published the "Belmont Report" in the early 1980s^{8,9} recommending guidelines under which human subjects may participate in medical research. Based on those recommendations, the U.S. Department of Health and Human Services (DHHS, formerly DHEW) and the Food and Drug Administration revised their guidelines, including provisions for informed consent procedures and an institutional review board to assess the risks and benefits of all potential research on human subjects. The revised guidelines did not prohibit research involving prisoners but required that "appropriate additional safeguards" be in place. However,

because prisoners were unable to satisfy the informed consent stipulation that requires potential participants to be free of all coercion in deciding to participate in a research trial, the regulation essentially eliminated all prisoner participation in clinical trials.¹⁰

HIV/AIDS IN U.S. PRISONS AND ACCESS TO EXPERIMENTAL THERAPIES

With the rise of the HIV epidemic in the 1980s, patients increasingly participated in clinical drug trials, gaining access to the newest medications. At the same time, the nation's so-called war on drugs began to affect court sentencing practices, with IV drug users and people involved in distributing and selling drugs receiving harsher, longer prison sentences.^{12,13} This, combined with the public's get-tough-on-crime attitude, has continued to concentrate large numbers of people at high risk for HIV/AIDS in the prison system.^{14,15}

In 1993, the AIDS incidence rates for men and women in the correctional system were about equal, in stark contrast with rates in the general population. In the general population, the AIDS incidence rate was 63.7 cases per 100,000 men, and 12.8 cases per 100,000 women. In the state/federal prisons, there were 340 cases per 100,000 men, and 408 cases per 100,000 women.⁵ The AIDS incidence rate in prison is more than five times as high for men and more than 31 times as high for women compared with the general population.

The historically inadequate medical care and general conditions found in prisons make the prohibition on experimental medications all the more unfortunate.¹⁶ Even as late as 1989, prison systems in 39 states and the District of Columbia, Puerto Rico, and the Virgin Islands were found to have unconstitutionally bad conditions, including overcrowding and poor medical care. In the mid- to late-1980s, several groups began to argue that prisoners should have access to experimental therapies for HIV infection,⁸⁻¹⁰ which spurred further revisions to the DHHS guidelines.

These revisions to the DHHS

guidelines specified the additional protections required for prisoners to participate in research, including a provision that the institutional review boards evaluating research involving prisoners include at least one prisoner or representative of prisoner interests in their membership.⁸⁻¹⁰ Despite the revisions, only a few states allowed prisoners to participate in research trials through the end of the 1980s. In June 1988, the Montefiore panel was established to address expanding prisoner participation in medical research, specifically in HIV-related clinical trials and epidemiologic research. The panel concluded that Phase II/III clinical drug trials that do not contain a strict placebo/no treatment arm do not violate the established DHHS guidelines.⁸ However, despite concerted efforts to increase prisoners' access to experimental therapies for HIV infection, only five states—Colorado, Maryland, New York, Texas, and Utah—allowed prisoners to participate in clinical trials through 1993.⁶

OBJECTIVES AND STUDY METHODS

Prisoners in Minnesota have not been allowed access to experimental therapies through clinical trials or through "parallel-track" programs (whereby drug companies provide medications to patients while pivotal Phase III clinical studies are being conducted). The reasons are unclear. The first objective of this investigation was to determine the current degree of participation in clinical drug trials and parallel-track programs in each state or district of the United States. The second objective was to determine what barriers prevent prisoners from gaining access to experimental medications, particularly through participation in clinical trials. Third, we wanted to determine how the states that allow prisoners access to experimental medications have overcome the barriers, and, specifically, how they have designed their programs for prisoner participation in drug trials. Finally, we intend to use this information to develop a program for Minnesota so that prisoners can participate in clinical trials.

We designed a survey that included questions to gauge the regulations, current participation in research, compliance with the federal regulations, and barriers to prisoner participation with research in each state. Key questions are listed in the table. Respondents were later asked to clarify or elaborate on their responses in an open discussion.

We used the American Correctional Association's "1994 Directory of Juvenile and Adult Correctional Departments, Institutions, Agencies, and Paroling Authorities" to identify appropriate officials within state correctional systems.⁷ We contacted the medical director or equivalent authority at each state/district DOC by telephone and explained the purpose of the study and survey. If we obtained consent, we conducted the survey, asking additional questions when necessary. On a few occasions, we requested written information from the DOC contact. We performed statistical analysis on a Macintosh computer using the JMP statistical package. We used the students' test to analyze the data, with a significance level of 95%.

RESULTS

We surveyed 32 of the 53 states and districts (60%), including 30 states, the District of Columbia, and the Federal Bureau of Prisons, with representatives from every region of the country and a wide distribution of HIV-seroprevalence rates (obtained from the June 1994 CDC/AIDS Surveillance Report).³ We excluded data from the District of Columbia and the Federal Bureau of Prisons from analysis because the AIDS case rate for the District of Columbia was so high it was an outlier, and no comparison data existed for the Federal Bureau of Prisons.

PRISONER PARTICIPATION

Of the 30 state correctional systems surveyed, nine (30%) have DOC policies that allow prisoners to participate in HIV-related clinical drug trials; 19 (63.3%) have policies that specifically prohibit participation in research; and two (6.7%) have ambiguous policies that may allow for individual participation in research,

despite the fact that medical research is not conducted in the correctional system. We placed states with ambiguous policies in the "prohibit participation" category, reasoning that prisoners in institutions without a policy do not have access to clinical drug trials. Survey responses supported this assumption.

CONTRIBUTING FACTORS—ACCESS TO CLINICAL DRUG TRIALS

Analysis revealed that a number of additional factors may be related to a state's policies on prisoner access to clinical drug trials: the 1994 state AIDS incidence rate (P value=0.002), the 1991 AIDS case numbers in correctional facilities (P value=0.0002), the number of cumulative deaths due to AIDS in the correctional system through 1993 (P value=0.0004), the percentage of minorities in the prisons (P value=0.0077), and the total amount of money spent per inmate per year in the correctional system (P value=0.0665—not statistically significant, but still demonstrates the relationship).^{3,7,17} For example, states with high 1994 AIDS incidence rates are more likely to allow prisoners to participate in research trials.

IRB STATUS AND DEGREE OF PARTICIPATION

No state that overtly prohibits prisoner participation in research trials is, in fact, allowing it. Furthermore, no prisoners in states with ambiguous policies were participating in research trials. Of the nine states that allow prisoners to participate in research, eight (89%) actually have had prisoners participate at some time. At the time of the survey, only New York had never had any participants. Iowa had not had participants since 1985.

The number of inmates participating in HIV research ranged from one to about 50 at the various prisons. The total number of participants was about 185, with about 150 (68%) in Texas and New Jersey. In most states, relatively few inmates have been enrolled in clinical trials, which could be because the inmates are not interested, or because the inmates do not fit the study criteria.

Every state that allows prisoners

Table

*Questions included in state DOC audits**

1. Have prisoners been enrolled in any clinical drug trials, specifically, HIV-related clinical drug trials?
2. If so, how many prisoners are enrolled in the studies?
3. Does the state/district have an institutional review board (IRB) or equivalent committee to evaluate potential research trials involving prisoners?
4. Is there a prisoner or representative of prisoner interests on this board?
5. What are the barriers to enrollment in clinical trials?
6. Do prisoners have access to experimental therapies via "parallel-track" or compassionate-use programs?

*Medical directors at state departments of corrections were surveyed about the policies regarding prisoner access to experimental therapies for HIV infection. The survey included these key questions.

to participate in research had an institutional review board to review potential research trials involving prisoners; only two of the nine states (22%) operate their own IRBs. Most states require that the institutional review board at the sponsoring institution (usually a hospital or university) approve the research trial for the correctional facility.

ACCESS TO PARALLEL-TRACK EXPERIMENTAL THERAPIES

Of the 30 states included in the analysis, 10 (33.3%) allowed inmates access to experimental therapies through "parallel-track" programs, 16 (53.3%) did not allow access, and four (13.3%) would be amenable to providing access through parallel-track programs. We reasoned that states that *might* allow prisoners to receive experimental therapies probably do not have any guidelines in place specifically allowing access, and that use of experimental therapies probably occurs infrequently. Thus, we placed these states in the "did not allow access" category.

PARTICIPATION IN RESEARCH VS. PARALLEL-TRACK PROGRAMS

We found no relationship between whether a state allows prisoners to participate in clinical drug trials and whether experimental therapies were

available through parallel-track programs ($X^2=0.714$, $\text{prob}>X^2=0.3980$). States were not more likely to allow or deny access to experimental therapies through parallel-track programs because of their policies governing prisoner participation in research trials.

CONTRIBUTING FACTORS—ACCESS TO PARALLEL-TRACK PROGRAMS

Analysis revealed that the following factors are related to states' policies on prisoner access to parallel-track programs: the 1994 state AIDS incidence rate (P value=0.0077), the number of cumulative deaths in the correctional system through 1993 (P value=0.0094), the percentage of minorities in the prisons (P value=0.0805), and incarceration rates in the correctional system (P value=0.009).^{3,7} Overall, states with higher rates of AIDS and minorities in their correctional systems were generally more likely to allow prisoners to obtain experimental medication via parallel track.

BARRIERS TO PARTICIPATION

Medical directors cited numerous barriers to prisoner participation in medical research, ranging from policy, legal, and ethical issues, to coordination problems, state or HIV population size, and the lack of opportunity.

Most of the states that cited legal issues were likely concerned about lawsuits if something went amiss during a study. However, they are also at risk for lawsuits over not allowing prisoners to participate in research, as one state reportedly experienced. Two states named cost as a barrier, suggesting that inadequate state funding may prevent prisoners from participating in research trials even if prison guidelines allow them to do so.

DISCUSSION

Correctional systems with high HIV/AIDS incidence rates generally have been forced to address HIV/AIDS treatment issues, including access to experimental therapies through participation in clinical trials or parallel-track programs, a community standard of care in much of the United States. Furthermore, the barriers that initially prevented prisoners from participating in clinical trials would have been addressed in those states where access to the newest treatment is viewed as an important part of an HIV/AIDS treatment program.

Notably, states that allow access to experimental medications through participation in clinical trials are not more likely to allow participation in parallel-track programs. In fact, if we investigate *overall* access to experimental medications (as opposed to access only through participation in research trials or parallel-track programs), 14 of 30 (46.7%) states have policies that specifically allow for access to experimental medications, and 20 (66.7%) *may* allow access (including states with no clearly defined policies). This means that a large number of additional states could be providing prisoners access to experimental medications.

Although not specifically addressed as a potential barrier, we found that the definition of "research" can prevent prisoner access to experimental medications. The problem is that the DOC guidelines rarely distinguish between research on drugs that have not been approved by the FDA and drugs that have already been approved. To eliminate confusion, clear definitions of permissible research should be included in the DOC guidelines.

One goal of this study was to facilitate changes in Minnesota policy, which now prohibits prisoners from participating in clinical drug trials, and to resolve the ambiguities surrounding the utilization of the parallel-track mechanism. Another goal was to develop a program through which state prisoners can try experimental therapies. The results of our survey indicate that it will not be difficult to design a program once the barriers are overcome. Several of the states we surveyed described exemplary cooperation between the state DOC and research institutions to facilitate prisoner access to experimental therapies. We recommend that Minnesota follow their example through the establishment of a program at St. Paul-Ramsey Medical Center, where many of the HIV-positive prisoners in the seven-county metro area receive their HIV care. The HIV Program at St. Paul-Ramsey Medical Center already has study nurses to enroll patients in clinical trials and knowledgeable staff with access to experimental medications through the parallel-track mechanism.

Work has already begun to establish a program allowing Minnesota prisoners to use experimental therapies. The institutional review board of St. Paul-Ramsey Medical Center has amended its cooperative agreement with the National Institutes of Health, thus allowing prisoners to potentially participate in NIH-funded studies. The board plans to work with the DOC to revise state guidelines regarding prisoner participation in research studies. Included in the revisions will be the stipulation that a prisoner representative participate in the institutional review board review of studies that could include prisoners.

MM

Abigail Collins is a first-year medical student at the University of California-San Francisco. Dana Baumgartner is a health care administrator, Minnesota Department of Corrections. Keith Henry is director of the HIV/AIDS Clinic and Programs at HealthPartners St. Paul-Ramsey Medical Center and an associate professor with the University of Minnesota Medical School. He also serves

as medical director for the St. Paul Department of Health's HIV and Sexually Transmitted Disease Clinic and is involved with the AIDS Clinical Trials Group sponsored by the National Institute of Allergy and Infectious Diseases.

REFERENCES

1. Altman LK. AIDS is now the leading killer of Americans from 25-44. *The New York Times* 1995 January 31: Sect. B:8.
2. Manning A. AIDS top killer in ages 25-44. *USA Today* 1995 January 31.
3. Centers for Disease Control and Prevention. HIV/AIDS surveillance report: U.S. HIV and AIDS cases reported through June 1994. Atlanta: Centers for Disease Control and Prevention, 1995;6:5.
4. Update: AIDS among women—United States, 1994. *MMWR* 1995;44:81-4.
5. Harlow CW. Bureau of Justice Statistics report: HIV in U.S. prisons and jails. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 1993.
6. Hammett TM, Harrold L, Gross M, Epstein J. 1992 update: HIV/AIDS in correctional facilities, issues and options. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1994.
7. 1994 American Correctional Association. Directory of juvenile and adult correctional departments, institutions, agencies, and paroling authorities. Laurel, Maryland: American Correctional Association, 1994.
8. Dubler NN, Sidel VW. On research on HIV infection and AIDS in correctional facilities. *Milbank Q* 1989;67:171-202.
9. Potler C, Sharp VL, Remick S. Prisoners' access to HIV experimental trials: legal, ethical, and practical considerations. *J Acquir Immune Defic Syndr* 1994;7:1086-94.
10. Hammett TM, Dubler NN. Clinical and epidemiologic research on HIV infection and AIDS among correctional inmates, regulations, ethics, procedures. *Eval Rev* 1990;14:482-501.
11. Brandt AM. Racism and research: the case of the Tuskegee syphilis study. *Hastings Cent Rep* 1978;21-9.
12. Mauer M. Americans behind bars: the international use of incarceration, 1992-1993. Washington, D.C.: The Sentencing Project, 1994.
13. Inmate census highest of all time: growth is linked to antidrug laws. *Star Tribune* 1994 September 13: Sect. A:7.
14. Holmes SA. Prisons replacing military as nation's hot growth area. *Star Tribune* 1994 November 13: Sect. A:17.
15. Holmes SA. Ranks of inmates reach 1 million in a 2-decade rise. *New York Times* 1994 October 28: Sect. A:1, A:25.
16. Mahon N. Where medical treatment is criminal. *New York Times* 1994 July 2: Sect. A: opinion page.
17. Watson T. Prisons' graying inmates exact a price. *USA Today* 1995 March 17: Sect. A:1.

ANNOUNCEMENTS

.....

LOOK FOR MMA COMMUNICATIONS UPDATE

The Minnesota Medical Association sent out a special publication to update members about important developments in the Medicare debate. The Communications Update also covered the impact of federal Medicaid cuts in Minnesota and the Vulnerable Adults Act requirement for criminal background checks.

...

NEW WORKERS' COMP CONVERSION FACTOR

On October 1, 1995, a new conversion factor of \$54.31 took effect for services provided under workers' compensation. The new conversion factor is 2.6 percent higher than last year's.

...

MMA BOARD OF TRUSTEES

The House of Delegates re-elected the following trustees:

Southwest

Thomas G. Birkey, M.D.

West Metro

Timothy J. Crimmins, M.D.

North Central

James J. Dehen, M.D.

West Metro

Gary Hanovich, M.D.

Southeast

David C. Herman, M.D.

Jerry P. Rogers, M.D., was elected as a new member of the Board of Trustees representing the Northwest District.

The MMA Board of Trustees re-elected as its chair Timothy J. Crimmins, M.D., F.A.C.E.P. Crimmins, a board-certified emergency physician, practices with Hennepin Faculty Associates in Minneapolis and is medical director of the Occupational Medicine Clinic at Hennepin County Medical Center and medical director of emergency medical services for the city of Edina.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Holds 142nd Annual Meeting in Rochester

At the 142nd Minnesota Medical Association Annual Meeting in Rochester, the MMA House of Delegates adopted 57 resolutions that set policy for the coming year. As top priorities, the MMA will pursue the goals yet to be achieved in the MMA's 1995 bill—the Quality and Coverage Act. In addition, the MMA will continue its “Stop the Violence” campaign and support a variety of public health and safety measures.

‘Quality and Coverage’—Still an MMA High Priority

The MMA reaffirmed its support for the goals of the MMA Quality and Coverage bill, which was introduced during the 1995 legislative session. The success the MMA achieved through this legislation, such as repeal of RAPO, won high praise from MMA delegates and leaders.

Andrew J.K. Smith, M.D., immediate past president of the MMA, said, “I give the Quality and Coverage bill an A+ for bringing physicians together in a shared purpose. We all pulled together and, as a result, we were very successful at the Capitol and won increased respect from state legislators.” The MMA House of Delegates voted to make it a high MMA priority to keep the momentum of the Quality and Coverage proposals going during the 1996 session and to submit any revisions that seem appropriate.

A number of MMA resolutions addressed specific Quality and Coverage proposals that did not pass last session. The MMA voted to contin-

ue urging legislators to pass the MMA tort reform legislation and to provide a substitute for the 2 percent provider tax, such as a tax on tobacco products. In addition, the MMA will continue to support legislation to increase the cigarette tax and to use some of the funds for smoking prevention and health care. The MMA will also continue to pursue legislation that would require each health plan operating in the individual, small-group, or large-group market to offer a point-of-service option in each of these markets.

MMA Continues ‘Stop the Violence’ Campaign

In a strong show of support for the MMA's “Stop the Media Violence” campaign, the MMA resolved to encourage all physicians to educate the parents of their pediatric patients on the MMA's “10 Tips on Media Violence.” The MMA also voted to continue working with the attorney general's office and other groups on violence awareness and prevention projects. The MMA will monitor the development of new technology that would allow parents to lock out violent programs, channels, and commercials and to study the concept of a rating system for television programming.

The MMA will call on the AMA to help promote similar campaigns against media violence throughout the entire AMA Federation. Several AMA anti-violence initiatives were triggered by previous MMA resolutions. “The MMA has set the exam-

Meeting continued on page 52



Viewpoint

• • •

Michael J. Murray, M.D.
President, Minnesota Medical Association

Changes in Medical Practice Raise Ethical Questions

Every recent MMA president has faced extraordinary challenges. Clearly, I will be no exception. The past few years have brought tremendous changes in the way we practice medicine. Minnesota's attempt at sweeping health system reform has resulted in greater consolidation. Managed care is increasing its penetration into the market and advances in medical technology are extending our research and treatment capabilities.

As the practice of medicine changes, we physicians are faced with new ethical dilemmas. At the recent MMA Annual Meeting in Rochester, we came together as an association to take positions on some of these ethical problems, as well as on policy issues. Our House of Delegates considered questions as diverse as how to maintain our traditional professional ethics in a managed care environment and whether it is ethical to remove the organs of anencephalic infants before death. As chair of the MMA Committee on Ethics and Medical-Legal Affairs, which has been discussing these issues, I was especially pleased with the outcomes.

Regarding the issue of ethics in managed care, the MMA House of Delegates voted to adopt the AMA Council on Ethical and Judicial Affairs' guidelines on avoiding the conflicts of interest that may arise in a managed care arrangement. In at-

tempts to reduce health care costs, managed care plans may create a conflict between the physician's traditional role as patient advocate and loyalty to the plan. For instance, health plans may expect physicians to consider not only the individual patient's needs, but also to weigh them against the need of the managed care organization to care for all its patients and to control costs. Plans may also create financial conflicts of interest between the physician and the patient by offering financial incentives to limit tests, procedures, or referrals.

Health plans certainly have a legitimate need to control costs, but some attempts to do so could create ethical gray areas for physicians. The AMA guidelines will help us avoid possible pitfalls in a cost-conscious managed care environment. Some of the key guidelines are as follows:

- Regardless of the delivery system, physicians must continue to place their patients' interests first.
- Broad allocation guidelines that restrict care and choices should be established at the policy level.
- Regardless of any allocation guidelines, physicians must advocate for any care they believe will materially benefit their patients.
- In some circumstances, physicians have an obligation to initiate appeals on behalf of individual patients or to advocate health plan policy changes.

- The physician's obligation to disclose treatment alternatives to patients is not altered by limitations in the coverage provided by the patient's managed care plan.

- Financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

In keeping with these ethical guidelines, the MMA House also voted to oppose mandatory one-day hospital stays for vaginal births and three days for cesarean sections. The appropriate post-partum length of stay and any follow-up care, including nurse home visits, should be determined by the physician and patient and not by an arbitrary time interval. Although financial considerations are important, final medical decisions should be made by the physician and patient, not by the insurance company.

The MMA House of Delegates also adopted policy on a very different kind of ethical issue, one that created some controversy and attracted media attention. The MMA voted to adopt policy opposing the AMA Council on Ethical and Judicial Affairs' position that it may be permissible under certain circumstances to use living anencephalic neonates as organ donors. Following the AMA position would place us not merely on a slippery slope, but on a cliff. Clearly, taking organs from anencephalic infants violates the prohibition against removing organs from a living person. Not only is it ethically wrong, but it could undermine public confidence in the entire organ transplant system. We do not want to arouse public fears that organs might be "harvested" before death. Currently, the dividing line between life and death for purposes of organ transplant is brain stem death. Any attempt to move this line would set a precedent that could lead to moving the line even farther to include those in a persistent vegetative state.

The MMA, in taking these positions, reaffirmed the belief that expediency does not change our ethics.

• • • • •

MMA Presents 1995 Awards

As part of the Minnesota Medical Association Annual Meeting festivities, the MMA presented awards for violence prevention, community service, service to the MMA, and service to a minority population. Awards were presented at the MMA annual awards lunch September 29 at the Kahler Hotel in Rochester.

'Stop the Violence' Awards

The winners of the "Stop the Violence" awards, which honor efforts to end domestic violence and abuse, are Alison J. Coulter-Knoff, M.D., David P. Walsh, Ph.D., Jack P. Duchow, and Turn Off the Violence.

Alison J. Coulter-Knoff, M.D., chair of the Hennepin Medical Society Abuse Prevention Project, has been working with the American Medical Association to develop guidelines for appropriate physician behavior in the medical workplace. Coulter-Knoff, a family practice physician in Roseville, also volunteers medical care at the Hennepin County Healthcare for the Homeless Project where many patients are victims or perpetrators of violence.

David Walsh, Ph.D., a psychologist at Fairview Behavioral Services in Minneapolis, is the author of "Selling Out America's Children." Walsh, who serves as a spokesperson in the MMA campaign against media violence, wrote an article in the June 1995 issue of *Minnesota Medicine* that addresses the link between violent entertainment and violent behavior. Accepting the award, Walsh said that anti-violence efforts are working. "In the last 24 hours, Time-Warner has divested itself of its 'gangsta rap' subsidiary," Walsh said. "This is just the beginning. Television, the great electronic teacher, can teach a healthy set of values rather than disrespect and violence."

Jack P. Duchow, an account manager at Minnegasco, stresses the corporate cost of violence. Duchow has worked to develop workplace violence prevention policies, produced

violence prevention videos in collaboration with WCCO-TV, developed workbooks and resource guides, developed leadership training manuals, and coordinated the production of theatrical performances on violence.

Turn Off the Violence, a coalition of more than 80 organizations including the MMA, promotes non-violent ways to resolve conflicts and helps people realize that violent entertainment makes violence seem more acceptable. The coalition has prepared brochures, community action guides, and educational idea guides to teach conflict management skills.

Community Service Awards

The winners of the 1995 Physician Awards for Community Service are John B. Sanford, M.D., Patricia Walker, M.D., and Theodore Will, M.D.

John B. Sanford, M.D., now retired from practice as a general surgeon in Duluth, continues to be active in his community and serves as a volunteer anatomy instructor at the University of Minnesota-Duluth School of Medicine. Sanford is one of the founding fathers and the president of the Rural Access Clinic in Cromwell, which provides free health care for low-income people.

Patricia F. Walker, M.D., who is board certified in internal medicine, is the lead physician at the International Clinic and International Travel Clinic at Ramsey Clinic in St. Paul. Fluent in Thai and Cambodian, Walker has worked tirelessly on behalf of refugees. At the height of the 1979 Cambodian refugee crisis, Walker worked with the American Refugee Committee on the Thai-Cambodian border. She also has served as the medical director for the International Rescue Committee at Khao I Dang Holding Center for Cambodian refugees in Thailand.

Theodore Will, M.D., a surgeon at the Bemidji Clinic, is active in the

Bemidji Rotary and through that organization has adopted a hospital in Santa Barbara, Honduras. Will and his colleagues shipped laparoscopic equipment that had been donated to the hospital in Honduras and taught a surgical team how to perform laparoscopic surgery. They also painted the hospital, built new school desks, and opened a clean water system to a nearby village.

MMA Award for Service to Minorities

The MMA presented a posthumous award to Donald Brown, Jr., M.D., honoring him for his many years of service to minority populations. Brown, a Minneapolis internist, followed a family tradition when he chose medicine as a career. His grandfather was the first licensed African-American physician in Minnesota, and his father was also a physician. Brown and his father set up a medical practice in a remodeled storefront in Minneapolis, where they were well-known and respected for helping people who could not afford to pay for medical care. Brown was very active in his community, in the Minneapolis Urban League, and in the NAACP until his death in June 1995. The family medical tradition continues. One of his daughters, Michelle P. Brown, M.D., is a surgeon in Williamsville, New York.

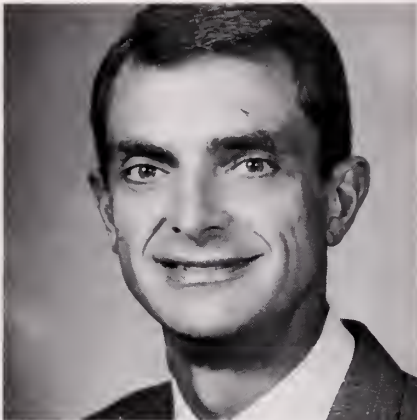
MMA President's Award

The MMA granted the President's Award to the following MMA members who have made outstanding contributions to the medical profession through their service in the MMA: Roger W. Becklund, M.D., of Robbinsdale; William M. Chandler, M.D., of Edina; J. Paul Marcoux, M.D., of Rochester; Thomas O. Nichols, M.D., of St. Paul.

The recipients of the President's Award serve on many committees and task forces and demonstrate over a period of years a willingness to volunteer their time and energy to their profession.

• • • • •

MMA Elects New Officers



Michael J. Murray, M.D., was inaugurated as MMA president during the Annual Meeting.

Meeting continued from page 49

ple nationally in its campaign against violence," said William E. Jacott, M.D., of Minneapolis, an AMA trustee.

MMA Supports Public Health and Safety Measures

The MMA adopted a number of resolutions aimed at improving public health and safety. In addition to reaffirming support for stricter enforcement of existing firearm laws, the MMA resolved to advocate tighter handgun control laws and to study the issue of the accountability of manufacturers and importers of firearms for the injuries caused by their products. In addition, the MMA resolved to introduce laws requiring a locking device for all firearms stored in homes where children live or are present.

In other health and safety measures, the MMA voted to support legislation requiring children to use life jackets or flotation devices; laws prohibiting smoking within 75 feet of any entrance to a facility that is designated smoke-free; laws to control air pollution; and legislative efforts to continue the existing ban on the public sale of fireworks. In addition, the MMA reaffirmed its policy supporting helmet laws for children riding bicycles, off-road vehicles, motorized wheeled vehicles, or snowmobiles. • • • • •

The Minnesota Medical Association elected its officers for 1995-1996 at the 142nd MMA Annual Meeting at the Kahler Hotel in Rochester on September 29, 1995.

President-elect

Raymond G. Christensen, M.D., a board-certified family physician and co-founder of the Gateway Family Health Clinic in Moose Lake, has been in active medical practice for more than 23 years. Currently, he serves as a rural consultant to the Outreach Department of the University of Minnesota Hospital and Clinic, as medical adviser to the Minnesota commissioner of health, and as the rural physician member appointed by the governor to the Minnesota Health Care Commission. He has been vice president of the MMA, the MMA alternate to the state's Region 2 Regional Coordinating Board, and a member of many MMA committees.

Vice President

Paul R. Hamann, M.D., who is board certified in both internal medicine and pulmonary diseases, practices part time at the Minnesota Lung Center in Minneapolis, which he co-founded, and is a consultant on administrative issues for several area hospitals. He is a member of the MMA House of Delegates and chair of the MMA Committee on Legislation.

Secretary

Judith M. Shank, M.D., is the founder and president of Metropolitan Dermatology, P.A. in Plymouth. Before becoming a physician, she was an assistant professor of nursing at Boston College. Shank has served on many MMA committees and has been a board member of MELD, a non-profit agency that strives to strengthen families through parent education.

Treasurer

Erick Reeber, M.D., was elected to his fourth term as treasurer of the

MMA. Reeber is a board-certified family physician in solo practice in Bagley. He has been a director of Midwest Medical Insurance Company since 1984 and chair of its Investment Committee since 1986.

Speaker of the House

Anthony C. Jaspers, M.D., is a board-certified family physician who practices at the Lake Crystal Clinic. He has served on the MMA Board of Trustees for nine years and has been vice speaker of the MMA House of Delegates.

Vice Speaker of the House

Blanton Bessinger, M.D., who is board certified in pediatrics and pediatric cardiology, is vice president of medical affairs for Children's Health Care-St. Paul and Children's Health Care-Minneapolis. Bessinger has been a delegate to the MMA House of Delegates for three years and has served as the MMA representative on the Health Technology Advisory Committee of the Minnesota Health Care Commission.

AMA Delegation

The results of the election for the Minnesota delegation to the American Medical Association are as follows:

A. Stuart Hanson, M.D.*
Ben P. Owens, M.D.*
Andrew J.K. Smith, M.D.

The alternate delegates are as follows:

Lyle Munneke, M.D.*
Bruce A. Norback, M.D.*
Thomas L. Peyla, M.D.*
John M. Van Etta, M.D.

Van Etta was elected to serve the remaining year for Randall Nelms, M.D., who is resigning from the delegation to represent his specialty society at the AMA. • • • • •

*Current members of the delegation who were re-elected.

MMA House of Delegates Sets Policy at 1995 MMA Annual Meeting

The 1995 MMA House of Delegates convened in Rochester September 28 and 29 to take action on 57 resolutions that will set the Minnesota Medical Association's course for the coming year. A summary of the House action follows.

Res. 1, Medical Decision-Making for Wards of the State

Adopted as amended.

The MMA will study Minnesota law and regulations establishing advance directives for patients who are state wards and will make recommendations to promote timely treatment decisions.

Res. 2, Appointment of Members to the Minnesota Board of Medical Practice

Not adopted.

Had asked that the MMA seek legislation requiring legislative consent to the governor's appointments to the BMP.

Res. 3, Suspension or Removal of Members of the Minnesota Board of Medical Practice

Not adopted.

Had asked that the MMA propose legislation to provide processes for suspending and removing BMP members.

Res. 4, Self-Treatment or Treatment of Family Members

Adopted as amended.

The MMA adopts the AMA Council on Ethical and Judicial Affairs' opinion that physicians generally should not treat themselves or members of their immediate family unless there is an emergency or unless the treatment addresses a short-term, minor problem. The MMA emphasizes the importance of appropriate documentation in self treatment or treatment of family members.

Sub. Res. 5, Ethical Issues in Managed Care

Adopted in lieu of resolutions 5 and 32.

The MMA adopts the AMA Council on Ethical and Judicial Affairs guidelines regarding ethical issues in managed care and resolves to hold a conference addressing these ethical issues.

Res. 6, Bylaws Revisions

Adopted.

Resolves that the MMA adopt bylaws revisions approved by the MMA Board of Trustees.

Res. 7, Direct Access to Preventive Health, Diagnostic, and Treatment Services of Obstetrician-Gynecologists

Adopted as amended.

The MMA supports the preservation of a woman's ability to directly access preventive health, diagnostic, and treatment services by obstetricians and gynecologists.

Res. 8, Rural Prepaid Medical Assistance Program (P.M.A.P.)—Study of Itasca Medicaid Demonstration Project

Referred to MMA Board of Trustees for study.

Resolves that the MMA: 1) Obtain and study the information available from the Prepaid Medical Assistance Program as it relates to access, quality, and cost of prepaid Medical Assistance health care in rural Minnesota; 2) formulate a report to the MMA membership; and 3) pursue legislation regarding the implementation of rural P.M.A.P.

Res. 9, Ban on Assault-Style Weapons

Withdrawn.

Had asked that the MMA support the development of non-lethal, defensive weapons to eventually replace most handguns.

Res. 10, Business Practices by Hospital, Clinics, and Other Health Care Providers

Referred as amended to the MMA Board of Trustees.

Resolves that the MMA support the practice of health care providers supplying itemized bills to their patients, including patients in capitated plans who request the information.

Res. 11, Minnesota Department of Health—Physician Clinic Survey

Adopted as amended.

The MMA will ask the Minnesota Department of Health to develop a task force composed of representatives of the MMA and other appropriate organizations such as the Minnesota Medical Group Management Association to redesign the Physician Clinic Survey in such a way that it uses accepted accounting methodology. In addition, the MMA will ask MDH and other regulatory agencies to undertake cost-and-time analyses before implementing reporting requirements for clinics, hospitals, and health plans.

Res. 12, Direct Contracting

Adopted as amended.

The MMA will study the "direct contracting" model and, if appropriate, will develop educational materials, offer seminars, or engage in other activities to enhance physicians' opportunities in direct contracting arrangements. If appropriate, the MMA will seek to work with the AMA to consider developing legislation to facilitate direct contracting by physicians and physician groups.

Res. 13, Conflict of Interest Laws and Corporate-Directed Medical Practice

Referred for study to the MMA Board of Trustees.

Resolves that the MMA recommend to the Legislature that all entities with any control of physician practices be subject to the same conflict of interest laws as physicians and physician-controlled groups and that the MMA call on the AMA to

Resolutions continued on page 54

Resolutions continued from page 53

request the same fair provisions from national regulations and legislators.

Res. 14, Center for Cross-Cultural Health

Adopted as amended.

The MMA supports the concept of the development, implementation, continued operation, and promotion of the Center for Cross-Cultural Health, which will serve as a clearinghouse, resource, and research center for health care providers. The MMA Board of Trustees will determine the level and type of support for the Center for Cross-Cultural Health.

Res. 15, State Funding of Medical Services

Adopted.

The MMA will take the following action: 1) review the state's role in financing and delivering medical care, 2) develop position statements regarding the reorganization and financing of the Medical Assistance and MinnesotaCare programs, and 3) continue to promote broad-based equitable funding sources for state medical programs.

Res. 16, Changing the Name of the Hennepin County Medical Society

Adopted.

The MMA approved changing the name "Hennepin County Medical Society" to "Hennepin Medical Society."

Res. 17, Immunizations

Adopted as amended.

The MMA supports insurance coverage of childhood immunizations and will specifically encourage self-insured companies to provide coverage for childhood immunizations. In addition, the MMA delegation to the AMA House of Delegates will introduce a resolution asking for federal legislation requiring self-insured companies to cover immunizations as recommended by the National Advisory Vaccine Committee.

Res. 18, Continuous Coverage for Children on Medical Assistance

Adopted as amended.

The MMA will seek to work with the Minnesota Department of Human Services to identify problems and potential solutions regarding quality of care, continuity of care, and access to services for patients in Medicaid managed care plans.

Res. 19, Support for Media Violence Campaign

Adopted.

The MMA resolves that the membership should strongly support the MMA's "Stop the Media Violence" campaign. The MMA will encourage all physicians to inform the parents of their pediatric patients about the MMA's "10 Tips on Media Violence."

Res. 20, Smoking at Building Entrances

Adopted as amended.

The MMA will initiate legislation to prohibit smoking within 75 feet of any entrance to a facility that is designated smoke-free.

Res. 21, Trauma System in Minnesota

Adopted as amended.

The MMA will develop policy and position statements regarding a trauma system in Minnesota and will report back to the House of Delegates in one year with recommendations for or against developing legislation.

Res. 22, Physical Therapy Assistants

Referred for study to the MMA Board of Trustees.

Resolves that the MMA support legislation to allow physical therapist assistants to treat patients without prior physical therapy evaluations when prior physician evaluation and recommendations have been made.

Res. 23, The Use of Anencephalic Neonates as Organ Donors

Adopted.

The MMA adopts policy opposed to the position of the AMA Council on Ethical and Judicial Affairs that it may be permissible, under certain circumstances, to use anencephalic neonates as organ donors.

Res. 24, Patient Record Confidentiality

Adopted as amended.

The MMA will seek legislation to permanently repeal the sunset provision in Minnesota law concerning data for medical and scientific research.

Res. 25, Repayment of Student Loans

Adopted as amended.

The MMA will actively work to repeal the law that makes failure to repay student loans grounds for disciplinary action by the Board of Medical Practice. Reaffirming its policy that all student loans should be repaid as rapidly as possible, the MMA resolves to encourage the use of existing mechanisms (e.g., wage garnishments, withholding of tax refunds) to ensure the full repayment of student loans by practicing physicians.

Res. 26, Tort Reform

Adopted as amended.

The MMA will continue to work toward passage of tort reform legislation introduced by the MMA in the 1995 legislative session.

Res. 27, Two Percent Provider Tax

Adopted as amended.

The MMA will continue to work for a substitute for the 2 percent provider tax, such as a tax on tobacco products or other mechanisms.

Res. 28, Maintaining Momentum in the Next Legislature

Adopted.

The MMA will continue its activities regarding the Quality and Coverage Act and will submit any revisions or augmentation that seem

appropriate during the 1996 legislative session. This activity will be a high MMA priority in 1996.

Res. 29, Telemedicine

Adopted as amended.

The MMA will convene a task force on telemedicine to develop a white paper on the need for guidelines and recommendations for the implementation and use of technologies. This task force should address the following issues: credentialing, licensure, reimbursement, practice standards, professional liability, technology, and common data systems.

Res. 30, Stop the Violence Campaign

Adopted as amended.

The MMA will continue to work with the attorney general's office and others to create a broad coalition to promote violence awareness and prevention and will monitor the development of new technology that would allow parents to lock out violent programs, channels, and commercials. The MMA will also study the concept of a rating system for television programming. If there is no AMA policy on this issue, the MMA delegation to the AMA will introduce a resolution calling on the AMA to work with the MMA to promote similar campaigns on violence in the media throughout the entire AMA Federation.

Sub. Res. 31, Post-Partum Hospital Stay and Nurse Home Visits

Adopted as amended in lieu of resolutions 31 and 48.

The MMA takes the position that an appropriate post-partum length of stay and any required follow-up care, including nurse home visits, should be determined by the physician and patient and not by an arbitrary time interval. The MMA will oppose mandatory reduced hospital stays of one day for vaginal delivery and three days for cesarean sections with the day of delivery being defined as day 0.

Res. 32, Ethical Conflicts with Managed Care

Sub. Res. 5 was adopted in lieu of resolutions 32 and 5. (See page 53.)

Res. 33, Bicycle Safety

Adopted as amended.

The MMA reaffirms current policy that supports legislation mandating helmet use for children under age 18 while operating bicycles, off-road vehicles, motorized wheeled vehicles, or snowmobiles.

Res. 34, Water Safety

Adopted.

The MMA will support legislation that mandates the use of life jackets or flotation devices for children under age 18.

Res. 35, AIDS Testing

Not adopted.

Had asked that the MMA support legislation that would treat HIV like other communicable diseases.

Res. 36, Under-Age Chemical Use

Referred to the MMA Board of Trustees for study.

Resolves that the MMA support legislation that would revoke the driver's license of any minor found driving with a blood alcohol level of 0.02 mg percent until the minor has reached age 21.

Res. 37, Snow Safety

Referred as amended to the MMA Board of Trustees for study.

Resolves that the MMA will study the concept of protective headgear and other methods of preventing injury to children under age 18 while downhill skiing and snowboarding.

Res. 38, Gun Control

Adopted as amended.

The MMA reaffirms its support for stricter enforcement of existing firearm laws and resolves to advocate tighter handgun control laws. The MMA will study the issue of accountability of manufacturers and importers of firearms for the injuries caused by their products. In order to reduce the risk of deaths and disabili-

ties caused by firearms, the MMA will develop and disseminate materials for physicians to share with their patients.

Sub. Res. 39, Medical Information Systems

Adopted as amended in lieu of resolutions 39 and 46.

The MMA will encourage physicians to record appropriate clinical information electronically so that duplication of effort is minimized and information can be electronically shared with various entities. In addition, the MMA Board of Trustees will study the feasibility of a single medical information system for the state of Minnesota.

Res. 40, Nursing Home Reimbursements

Adopted as amended.

The MMA will encourage the AMA to urge HCFA to revise rules governing Medicare reimbursement for skilled nursing facility care so that payments would not be contingent on a patient being hospitalized three consecutive days and will seek to work with the AMA to educate Congress on the financial implications of this rule.

Res. 41, Preventive Services Guidelines

Adopted.

The MMA supports the continued development of the Preventive Services Guidelines and will assist in their promotion, distribution, and implementation. The MMA takes the position that the guidelines should be considered a floor on preventive services and should not be used to limit cost-effective, preventive health care practices that might be developed in the future or be used as a guide for reimbursement.

Res. 42, Cost of Copying Medical Records

Adopted.

The MMA will support legislation requiring health plans to reimburse for the cost of copying a patient's medical record if the patient

Resolutions continued on page 56

Resolutions continued from page 55

must change physicians because of health plan requirements, necessitating the transfer of medical records.

Res. 43, Tobacco Tax Increase

Adopted as amended.

The MMA will support legislation in 1996 to increase the cigarette tax substantially and to designate an acceptable percentage of the funds for smoking prevention and health care.

Res. 44, Obstetrician-Gynecologists as Primary Care Providers for Women

Withdrawn.

Res. 45, Retroactive Denials

Referred for study to the MMA Board of Trustees.

Resolves that the MMA work with third-party payers and the MDH to establish a mechanism to identify the problems resulting from retroactive denial and to propose solutions to these problems.

Res. 46, Multiple Management Information Systems in Health Care

Sub. Res. 39 was adopted, as amended, in lieu of resolutions 46 and 39. (See page 55.)

Res. 47, Point-of-Service Requirement

Adopted.

The MMA will continue to pursue in 1996 legislation that would require each health plan operating in the individual, small group, or large group market to offer a point-of-service option in each of these markets and require the cost of this point-of-service option to be actuarially justified.

Res. 48, Opposition to Mandatory Reduced Hospital Stays

Sub. Res. 31 was adopted in lieu of resolutions 48 and 31. (See page 55.)

Res. 49, Air Quality

Adopted.

The MMA will support legislation to protect human health and control air pollution and takes the position that air quality standards should be established using the best available scientific data.

Res. 50, HIV Testing of Pregnant Women

Adopted.

The MMA supports the routine offering of the HIV test to all pregnant women and resolves to disseminate information about this issue to all Minnesota physicians.

Res. 51, Pediatric Immunization Standards

Adopted.

The MMA endorses and will disseminate the Standards for Pediatric Immunization Practices recommended by the National Vaccine Advisory Committee.

Res. 52, Guidelines for Adolescent Preventive Services

Referred to the MMA Board of Trustees for study.

Resolves that the MMA convene an ad hoc task force of health care payers and providers to explore opportunities to implement the AMA Guidelines for Adolescent Preventive Services.

Res. 53, MMA Endorsement of Sexual Assault Resource Service

Adopted as amended.

The MMA endorses the activities of groups such as the Sexual Assault Resource Service and supports the expansion of such groups throughout Minnesota.

Res. 54, Continued Prohibition on the Public Sale of Fireworks in Minnesota

Adopted.

The MMA will support legislative efforts to continue the existing ban on the public sale of fireworks, including sale by mail order, and will work with appropriate organizations and state agencies to achieve the continued ban. The MMA will also support efforts to educate physicians, parents, children, and community

leaders about the danger of fireworks and will encourage the state legislature to continue the ban on fireworks except for those used for professional displays.

Res. 55, Merger of Wakota County Medical Society with Ramsey County Medical Society

Adopted.
The MMA approved the merger of the Wakota County Medical Society and Ramsey County Medical Society and a charter for the new entity, which will be called the Ramsey Medical Society.

Res. 56, Speed Limit

Adopted as amended.

Recognizing the relationship between driving speed and the severity of injury in automobile accidents, the MMA will urge policymakers to consider this relationship before adopting any changes in state speed limits.

Res. 57, Mandatory Firearm Locks for Homes with Children

Adopted as amended.

The MMA will introduce legislation mandating the use of a locking device for all firearms stored in homes where children 18 years of age or younger live or are present. • • • • •

The Monitor

NOVEMBER 1995

• • •

PRESIDENT

Michael J. Murray, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR, COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

• • •

TRY US ON FOR SIZE

A UNIQUE OPPORTUNITY FOR YOU TO CHOOSE THE SIZE OF COMMUNITY AND LIFESTYLE THAT SUITS YOU BEST.

From the tranquility of rural communities to the stimulating environment of a large Midwestern community, complete with universities, MeritCare has just the right fit for you. The 15th largest group practice in the U.S. offers a network of medical care facilities, including secondary and tertiary locations. Enjoy a wide range of practices and the camaraderie and support of over 270 doctors in 45 specialties.

Professional Opportunities Available:

- Family Practice
- Psychiatry
- Psychology
- Orthopaedics - Detroit Lakes, Bemidji
- Child/Adolescent
- Urgent Care
- ENT - Bemidji



For more information contact:
Kathleen McKittrick Toft,
 Director, Physician Recruitment
1-800-437-4010

 **MeritCare Medical Group**
 737 Broadway • Fargo, ND 58123



A Walk In The Park



Discover Preferred Seniors—the health plan where preventive dental, low rates, and worldwide emergency coverage are second nature.

Please join us for a continental breakfast and to learn more about this exciting new product. You will have an opportunity to register for a door prize with no obligation.

Sponsored by Minnesota Physicians Insurance Agency.

Minneapolis—Friday, November 17 1995

10:00 a.m. to 11:30 a.m.

Sheraton Minneapolis Metrodome Hotel
 1330 Industrial Boulevard at 35W North

Please RSVP to Sandy Cherry at (612) **623-2860** or for more information about Preferred Seniors, please call (612) **456-5050**.

© Registered marks of the Blue Cross and Blue Shield Association
 © 1995 Blue Cross and Blue Shield of Minnesota



**BlueCross BlueShield
 BluePlus
 of Minnesota**

Independent licensees of the Blue Cross and Blue Shield Association

We challenge you...

**You say you want a
comfortable retirement,
college education for your kids
and security for your family.**

**Be honest...
what are you really doing about it?**

Everyone says they want a comfortable retirement and anyone can sell you a product. The difference in working with MMBR is that we have systems and people, endorsed by the association, that will challenge you with the tough decisions required for success.

No wasted time or sugar coating. As part of the MMBR high value mission, Minnesota Physicians Insurance Agency counselors are experienced professionals trained to help you to prepare for the future you really want.

So, if you really want to do something about your future call MMBR and ask about our no hassle, to the point, financial reviews.

Make tomorrow happen by taking the challenge today!



Upcoming Seminars:

November 15, 6:00pm-7:30pm
Strategies to maximize retirement income by decreasing your tax burden.

January 24, 6:00pm-7:30pm
Practice Succession Planning.
What happens to my practice in the event of death or disability?

**Space is limited. Call now to
reserve your seat.**

MPIA brings you high value services including:

- ★ Tax favored programs to help you build capital.
- ★ Insightful retirement, and estate planning.
- ★ Comprehensive employee benefit services.
- ★ Quality life insurance and disability income coverage.

For assistance with your insurance or financial needs or to reserve a place at an upcoming seminar, please call **(800) 298-6627**.

MPIA
MINNESOTA PHYSICIANS
INSURANCE AGENCY
A MMBR company

Two for the Show: EDI and Electronic Commerce

EDI improves the efficiency and cuts the costs of countless health care-related business transactions. Second of three parts.

Sue Chapin-Strike

Electronic data interchange, the computer-to-computer exchange of data in a standard format, speeds the flow of data, such as claims and payments, between health care organizations. The first article of this series, "One for the Money: The Financial Benefits of EDI" (October 1995, page 52), told how EDI can improve a health care organization's cash flow, for example, by speeding Medicare payments. This alone is probably enough to warrant the implementation of EDI. However, claims processing is only one of many uses for EDI. It also can be used to process enrollment and verify eligibility, and it can support nearly 300 different business transactions, including contracts, purchase orders, invoices, payments, test results reporting, and the coordination of benefits. This month's article describes some of EDI's many uses.

ENROLLMENT AND ELIGIBILITY

For EDI to be of value, databases must be accurate and synchronized between organizations exchanging data. Therefore, the electronic data cycle must begin at the beginning—with enrollment in a health care plan. Blue Cross and Blue Shield of Minnesota is one company that is already using EDI for enrollment. The time savings are significant. As an example, one BCBSM enrollee changed his selected primary care clinic on a Friday afternoon; the transaction was quickly transmitted, the plan system updated, and a new membership card put in the mail. The employee received his card the following Wednesday, only five days after requesting the change, a dramatic improvement over the normal four-to-six-week cycle.

In a capitated environment, the next logical step is the communication of roster information from the plan to the clinic. This saves time for patients and clinic staff. When the patient seeks care from a new clinic, the front desk is able to retrieve current information for registration. (By requesting eligibility information from the plan at the time of the patient's visit, the clinic may choose to validate the information's accuracy in a real-time mode.)

Such a system is already under study in Minnesota;

HealthPartners is testing the Interactive Eligibility Inquiry (IHCEBI) and the Interactive Eligibility Response (IHCEBR).^{*} With this system, the patient presents a health care identification number or card at the time of registration, which is entered into a computer. The computer converts the request into the universal language established by the American Standards Committee X12 (see the October article, page 52) and transmits the request for eligibility to the plan via telecommunication lines. The plan responds with information on plan participation. The plan's response may include details regarding prior authorization requirements, copay amounts, and covered services, as well as recognition of the patient's participation in the plan.

In the not-too-distant future, requests for eligibility will likely occur as easily as credit card validations or cash withdrawals from an ATM machine. A simple swipe of an electronically encoded card will generate the requested information, with a response occurring within seconds. Just as the banking and credit industries have agreed to support standard technology for the decoding of information stored on a card, the health care industry will likely take similar steps. And just as ATM cards require an authorization code (a personal identification number, or PIN), similar measures are needed to ensure the security and confidentiality of patient information.

CLAIMS

Using EDI, all claims and payments can be electronically communicated using standard documents created by the

^{*}The IHCEBI and IHCEBR documents were created under EDIFACT, an international standards setting body of the United Nations. The ANSI X12 documents, which support this function, are the 270 Health Care Eligibility/Benefit Inquiry and 271 Health Care Eligibility/Benefit Information. The documents differ in their basic construct to support different business needs. The 270 and 271 are designed to support batch transmission, whereas IHCEBI and IHCEBR are designed to support interactive, or real-time, exchange of data.

American Standards Committee X12. When a patient receives care, the encounter or claim information is electronically communicated to the payer. To check on the claim, the clinic can generate a claim status request and receive a claim status notification. Payers may also initiate a claim status notification if there is a problem with the claim.

Once the claim has been adjudicated, the payer initiates the health care claim payment/advice. This is a dual-purpose document that may be used to initiate an electronic funds transfer, as well as communicate the data associated with the payment. If referrals are made or results reported, two additional documents, patient information and health services review, come into use.

No discussion of EDI would be complete without mentioning attachments, such as treatment plans. Although the need for attachments has not yet been eliminated entirely, the federal Health Care Financing Administration, the agency responsible for Medicare, recently announced that two of its attachments (700 and 701) can be replaced by including the information in ASC X12.

PROCUREMENT

EDI is not limited to patient-specific applications. The vision for EDI encompasses all exchanges of information between health care organizations and their trading partners. Procurement is perhaps the most widely used EDI function in health care today. Hospitals receive catalogs and contracts electronically, eliminating the time and errors related to updating inventory control systems with product and price information. Purchase orders are electronically submitted to suppliers, who respond with purchase order acknowledgments, advanced ship notices, and invoices. The cycle is completed by generating a payment order/remittance advice.

More progressive health care organizations document supply usage electronically using bar code technology, transmitting the information at point of use. Not only does this reduce the amount of inventory needed on hand by assuring rapid replacement, but it also improves the bottom line by reducing "lost charges" (charges not tracked to the patient). Some organizations have chosen a vendor-managed inventory control program. In such a system, the vendor tracks supply levels and determines when to replenish products following parameters set by the health care organization. The vendor transmits an advanced ship notice to indicate that the replenishment product is en route. The number of documents is further reduced when the vendor combines the advanced ship notice with invoice information in a single document, called the bill and ship notice.

Many organizations have had great success using standard EDI for procurement. For example, electronic invoicing allowed the U.S. Department of Veterans Affairs to reduce its clerical staff by 14 FTEs after 20 percent of its suppliers began using the system. This cost reduction was a bonus; the VA's original intent in using EDI was to speed invoice processing so it could take advantage of prompt payment discounts. Previous-

ly, it had been unable to process invoices within the terms window. Today, the VA processes more than 90 percent of its electronic invoices in time to receive these discounts.

CONCLUSION

Many of the nearly 300 standard EDI transaction sets have the potential to reduce health care costs associated with mundane, repetitive tasks and to improve access to information. As a result, resources can be reallocated toward improving quality and increasing physicians' time with patients.

The final article of this series, "Three to Get Ready: How to Implement EDI," in next month's *Minnesota Medicine*, will review the resources required to initiate EDI. Although the underlying technology may seem complex, careful planning can ease the challenge, as well as the cost, of transition. MM

Sue Chapin-Strike is director of the Minnesota Center for Healthcare EDI. As a faculty member for several organizations, including the Health Industry Business Communications Council, the Healthcare EDI Coalition, the Health Information Management Systems Society, and the Data Interchange Standards Association, she has delivered more than 40 seminars nationally on health care EDI. She has contributed articles to several magazines and journals, including EDI World, for which she served as a contributing editor for more than two years.

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

*COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes*

C. F. ANDERSON CO., INC.

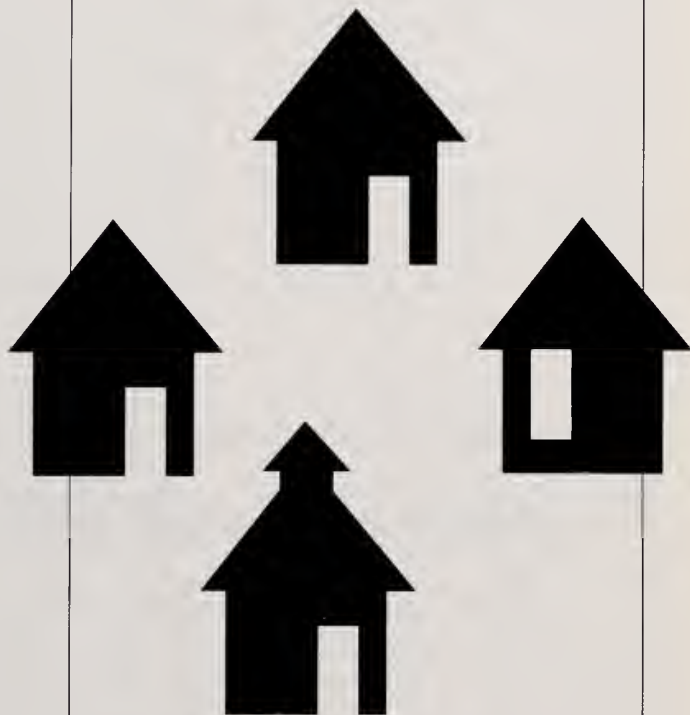
10925 Nesbitt Avenue South
Bloomington, MN 55437
Local (612) 881-0618
WATS (800) 328-6246
FAX (612) 881-7297



C. F.
anderson
COMPANY, INC.

Children on ventilators...

When young people need this complex form of care, there's a place with experience and successful outcomes.



Since 1988, we have provided comprehensive inpatient and outpatient medical, rehabilitative and habilitative care to infants, children and adolescents who require a ventilator or have an airway obstruction. Medical conditions include:

- *spinal muscle atrophy*
- *muscular dystrophy or polio*
- *spinal cord injury or anomaly*
- *central breathing dysfunction*
- *premature infants with bronchial-pulmonary dysplasia or chronic lung disease*

Our goal is to return these young people to their home and community.

To refer a patient to the TDR program, or for a copy of a 10-minute educational video, call **(612) 229-3954**.

Gillette
Children's Hospital

200 East University Avenue
St. Paul, Minnesota 55101

SIMPSON & SCHUT

(continued from page 7)

addition of Ron Schut as a second full-time physician and director of HIV clinical research in 1993, she says.

More than Medical Care

Simpson and Schut work much like partners in a typical primary care practice, spending most of their time seeing clinic patients, doing inpatient rounds, and cross-covering for each other. But unlike physicians in more typical practices, they deal with much more than medical concerns during their clinic encounters.

"We realized early on that AIDS is more than a medical disease," says Simpson. "As a facility, we had already recognized that many of the diseases we deal with in a stressed urban population involve much more than the medical component."

One of the goals of the HIV/AIDS Program is to anticipate the patient's disease process and to prevent difficulties down the line. How will the patient pay for treatment? Is housing a problem? Does the patient need help writing a living will? Staff social workers and case managers are available to help patients assess their needs, look at options, and make appointments to obtain assistance if necessary.

"We want to know when day-to-day living is becoming a problem," says Simpson. "Is putting food on the table a problem? If it is, is it because they can't get to the store? Are they too tired to cook? Or can't they remember when they last ate?"

"With this patient population, it is naive to think that visiting a doctor to discuss medical implications is enough," Schut says. "There is so much more involved—other kinds of support are as important, if not more important, than medical care."

Research and Treatment

Originally from Golden Valley, Minnesota, Schut earned his medical degree at the University of Minnesota

in 1986. As a research fellow at the University of Minnesota, he was involved in laboratory research that linked the presence of cocaine and opiates to a more rapid growth of the HIV virus in cell cultures.

As a student, Schut's original interest had been in neurology. His father is a neurologist, and a genetic, progressive neurological disease is part of their family history. But with time, Schut became interested in infectious disease, something he saw as covering all spectrums of age and disease processes, Schut explains. While he did not originally intend to concentrate on HIV, Schut says that his attraction to the county hospital and the populations it serves led to that eventual focus.

In addition to providing patient care, Schut's goal as director of clinical research is to provide quick access to newer medications and protocols for the patients at HCMC. As a sub-unit of the Minnesota AIDS Clinical Trials Unit (ACTU), HCMC's only access in recent years to experimental trials was through the national AIDS Clinical Trials Group (ACTG).

"While the ACTG is very valuable, they can only provide so many opportunities," Schut explains. And those opportunities are often slow in coming. Some companies, he notes, are doing their own trials not through the ACTG/ACTU. "We want to provide our patients with comparable access to all newer agents—the same access as anyone else in the country might have."

Toward that goal, Schut formed a loose coalition with physicians at the Park Nicollet Clinic and St. Paul-Ramsey Medical Center, known as the AIDS Research Coalition of the Twin Cities (ARCTiC). Through the coalition, HCMC actively seeks out companies working on new AIDS drugs that appear promising and submits a proposal to serve as a trial site for the drug. This gives HCMC patients quicker access to experimental drugs, while providing the drug company with documented data on how the patients are doing on the new agents, says Schut.

As much of the focus of patient care has turned to preventive treat-

ment for those who are HIV positive, Simpson and Schut agree that the biggest challenge is knowing when to start treatment and what therapies, or combination of therapies, to use.

"What makes intuitive sense is to start right away, as soon as the patient is diagnosed," says Schut. "But we still don't know how to best mix and match therapies to achieve the optimal benefit." Any medication builds up toxicity with time, and the therapeutic benefits wane after a while, Schut explains. There may also be side effects. "A patient who feels terrific may ask how meritorious it is to take a drug several times a day that has side effects and that is also costly."

Earlier treatment may keep the patient healthier longer, Simpson notes. But if many of the available agents lose their effectiveness (or become toxic) during the healthy period, there may be fewer options for patients as they become more ill. To help solve the dilemma, the program is exploring the use of combination and intermittent therapy as possible options, says Simpson.

For the person living with AIDS, waiting for newer agents to become available is a very slow and frustrating process, says Simpson, noting that the average life expectancy for a person diagnosed with AIDS is two to four years. When it comes to providing patients with treatment options, "we want to be the ones on the cutting edge."

Future Challenges

As the result of a great deal of advocacy and other work, AIDS funding and education have improved significantly in recent years, Simpson points out. But along with improvements have come new challenges related to treating a disease that is taking a stronger hold on varied populations. While at one time AIDS primarily affected gay and bisexual men, 70 percent of the new cases being diagnosed today in the United States are among IV drug users, newborns, and heterosexual persons of color.

Locally, Minnesota Department of Health statistics show recent jumps in the total number of women and IV drug users who have contracted AIDS

since 1982. Between September 1994 and August 1995, the number of women who contracted AIDS through heterosexual contact jumped 20 percent. In that same period, the total number of men and women who contracted AIDS through IV drug use increased 14 percent.

"AIDS is a very political disease," Simpson says. "When people talk about it, it is not uncommon for their personal viewpoints and opinions to become involved." Although early ignorance and irrational fears about AIDS have diminished, they have not disappeared. People with HIV and AIDS are not always treated with compassion, says Simpson.

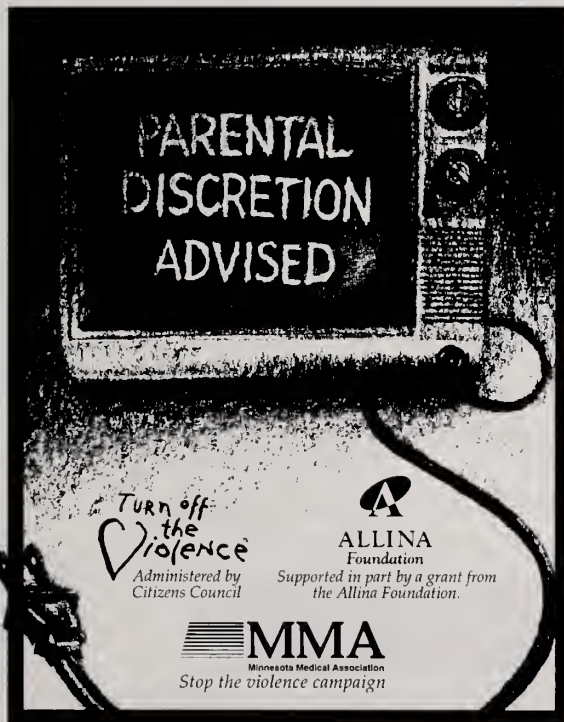
Simpson and Schut fear that a growing population of urban victims

may have fewer advocates for the future dispensation of health care dollars and research funding. It is a population that traditionally has much less of a support system than some other groups, Schut says.

Schut also fears that proposed cutbacks in Medicare and Medicaid funding could affect patient access to many of the services that they currently receive at HCMC. For example, because psychosocial services are hospitalwide, funding cuts would probably limit overall patient access to such programs, he says. "I would be very concerned if that happened, because social services are such an important part of caring for our patients [in the HIV/AIDS Program]," Schut adds.

With time, there is also a danger of public and political burnout or apathy toward the epidemic, Schut believes. If media attention diminishes, so might the public's interest. "This is a disease at risk. There is an ongoing need for public awareness about prevention, and people need to be empowered to say no [to behaviors that put them at risk]," says Schut. "I would hate to see dollars, fundraisers, support, and interest wane." MM

Katie Colón is a free-lance writer in Champlin, Minnesota, specializing in health care and disability-related subjects.



Stop the media violence

Media violence is a health hazard to kids. As a physician, you can help by educating patients! Provide parents with information on taking charge of the media in their children's lives by limiting viewing, providing choices, and talking about what is being shown.

For further information, or to order posters and brochures to display in your office, contact:

Minnesota Medical Association
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
612-378-1875

AIDS

(continued from page 14)

Schools: A Political Playground

Nobody knows that better than the Anoka-Hennepin Independent School District. Last year, in a review of its K-12 health curriculum, which includes a component on AIDS and HIV, the state's third largest school district found itself up against a concerted effort to thwart the AIDS curriculum.

Since 1988, the Minnesota Legislature has mandated that all schools include AIDS education in the K-12 curriculum. "In the majority of our communities there are well-planned efforts that have continued for a long time," says Ruth Ellen Luehr, prevention and risk-reduction specialist with the Minnesota Department of Education. Luehr acknowledges that from the start, some parents have raised concerns about the AIDS curriculum, and adds that such scrutiny has always been welcome because it helps to refine the instructional program.

But the situation in the Anoka-Hennepin schools is different. "We're seeing a more organized effort to rally parents and give them specific direction on both their rights and ways to influence the curriculum," Luehr says. "According to press reports, the Minnesota Christian Coalition and the Minnesota Family Council have been providing leadership and organizing parents who oppose current sexuality programs."

Close observers fear that what happened in the Anoka-Hennepin schools is likely to be played out in other districts. A committee of 25 teachers, staff, and parents spent eight months reviewing the health education curriculum as part of a regular review process. The committee produced a majority report concluding that the existing curriculum was good. But a minority report, signed by five of the members, raised questions about the curriculum.

One of their concerns was that homosexuality would be discussed as normal or a valid lifestyle. It's

never discussed as a "lifestyle," Luehr explains, although it is included in the curriculum as part of the disease prevention unit, and the unit on understanding sexuality. Judgments about the moral nature of homosexuality are not part of the curriculum, but the minority view is that "simply talking about it sanctions it," says Luehr. The minority group also asked that MAP be excluded as an educational resource. In June the school board accepted both reports, even though they were contradictory.

Wendy Graves, a parent who signed the majority report, is troubled by the school board's acceptance of both reports and believes the board was bullied into doing so by a well-orchestrated protest on the part of the minority group. Graves, who formerly served as the AIDS/HIV education chair for the Minnesota PTA and is now that organization's president-elect, worries that these parents are obstructing the review process and shifting the focus from the health aspects of AIDS education to the political aspects.

Graves is aware that other school districts in the state, including Winona, Forest Lake, Apple Valley, and Duluth, are experiencing challenges from similarly organized groups. "This is a nationwide effort," she says, spearheaded by groups like the Christian Coalition, which targets school boards. "They train individuals to get onto these committees and push their agendas."

The Physician's Role

One of the most effective ways to defuse these potentially volatile situations is through the dissemination of accurate information, and physicians can play a role in that regard. "In a number of communities in the state, the expertise of physicians and nurses has helped make the curriculum current, accurate, and complete, and sometimes less likely to be swayed by smaller groups of anxious parents," Luehr says.

Luehr encourages physicians to get involved in curriculum development by serving as advisers to school boards or by sitting on curriculum committees. "As community leaders, they can have a role in assisting the

district with designing and revising policy at the district level," she says.

Teel agrees that doctors play a crucial role in the education process. "Just like they do with heart disease, cancer, and diet—they routinely talk about these things. HIV needs to be routinely addressed," she says. "I want the doctors to hear how important it is to not be silent about this issue. Their silence is an oppressive and deadening silence. There is no community in this state that has not had one person living with AIDS."

According to Strickland, efforts have been made in the past few years to encourage primary care providers to offer AIDS education as part of routine office visits. The message can be delivered during school physicals, Pap tests and pelvic exams, well-child exams, and when patients come in with concerns about venereal diseases or birth control. "Those are all logical times to include HIV prevention," he says.

Strickland adds that physicians also can play a role in the community, although he recognizes how difficult that can be. "Physicians, in general, are not very politically active," he says, "and this requires a lot of political activity. They're uncomfortable talking about sex with their patients, and this requires talking about sex. You have to be political in the AIDS arena. You have to be willing to come up against school boards and support ones that want to do AIDS education."

A Bumpy Ride

So this is what it means to provide AIDS education 15 years into the epidemic. It means getting the message out at a time when political backlash, fatigue, and complacency have set in. And it means repeating the message over and over, because accurate information is the only weapon against AIDS. But it won't be easy.

"We're in for a bumpy ride," Teel says. "What's going to happen as a result of that bumpy ride is that unnecessary deaths will occur in frightening numbers. If we take our foot an inch off the pedal of prevention, we will lose so much ground. That is what's so frightening."

The only recourse is mobilizing at the grassroots level, Teel adds. "You must be willing to stand up at the Anoka-Hennepin school board meeting and say, 'My son is HIV positive. He's 24 years old. I have a 15-year-old in the school system. This

is an important issue for me.' Until we can get to that point, we will lose." MM

Miriam K. Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

HealthEast Capitol Medical Laboratory offers solutions

Providing services to physician office laboratories, long term care facilities, home care agencies, group homes, and corporate health and wellness programs • Professionally staffed • Locally owned and operated • Open 24 hours, 7 days/week • Member HealthEast Community Based Services

Providing solutions and expanded services for your office. For more information, contact CMLMarketing at (612)

232-3246

HealthEast  Capitol Medical Laboratory

69 West Exchange Street
St. Paul, MN 55102

Customer Service: (612) 232-3500

• Minnesotans serving Minnesotans •

ASPEN
Medical Group 

Internal Medicine

Opportunities available for BC/BE physicians to join multi-specialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 14 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612/642-2779
FAX 612/642-9441

**"We love it here.
Depending on the
season, we're
minutes from skiing
or hiking."**



Rita Hsu, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a 55 year-old, multi-specialty group of 115+ physicians, has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE

• Ophthalmologist (w/surgical retina)

OMAK/MOSES LAKE

• Family Practice w/OB
• Orthopedist

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711
ext. 5203



**Wenatchee
Valley
Clinic**

An auto lease/purchase company solely dedicated to serving physicians.

MMBR Motor Services



Here's what MMBR Motor Services is committed to doing for you:

When you call us, we go to work providing free consultation to help you outline your vehicle needs, and identify your choices. We then provide one free MSRP dealer's invoice price list.*

We offer one-stop convenience, providing access to all makes and models of new and used cars, trucks, conversion vans, sport utility vehicles, and luxury cars.

In all but the rarest circumstances, we *guarantee* that you will never pay more than factory invoice on domestic vehicles, and you will always receive the lowest market price on imports. In any case, you can count on receiving the best value available.

Upon your request, we will arrange for delivery of your vehicle anywhere in the United States.

We will find a buyer for your old vehicle. Or, if you prefer to sell your old car on your own, we can give you an idea of what the car may be worth.

And here's something special from MMBR Motor Services. Twice during the first three years of your lease we will arrange to have your vehicle professionally detailed, assuring high resale value by helping keep your vehicle in top condition.

We provide complete support after the lease/purchase. If you have a question, call us.

For *personal attention* on your next automobile lease or purchase, call MMBR Motor Services, 612/623-2860, toll free 1-800-298-MMBR.

*Additional price lists are available at a nominal fee. These fees are applicable toward the lease or purchase of a new vehicle.



MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

A physician-owned, for profit
corporation of the MMA and HMS

People and Places Making Medical News

People

HCMC Appointments

Hennepin County Medical Center has appointed several physicians to new posts. In July, Lawrence Kerzner, M.D., became HCMC's new chief of geriatric medicine. Previously, he was chief of medicine and medical director, Jewish Memorial Hospital in Boston; clinical professor of medicine, Boston University School of Medicine; and co-director, fellowship in geriatric medicine, Boston University Medical Center.

Mark Martens, M.D., in August became the medical center's new chief of obstetrics and gynecology. He came to HCMC from Emory University School of Medicine in Atlanta, where he served as an associate professor, director of the Division of Gynecology, and head of infectious diseases in the Department of Gynecology and Obstetrics.

Steven Goldsmith, M.D., is chief of the Division of Cardiology. He has been an HCMC cardiology staff member since 1981, and also is a professor of medicine at the University of Minnesota Medical School. He succeeds Morrison Hodges, M.D., who retired in June after directing the Cardiology Division for 21 years.

Tanya Repka, M.D., is the new chief, Division of Hematology/Medical Oncology. She has been an HCMC staff member since 1991 and is an assistant professor of medicine at the University of Minnesota Medical School. She succeeds Brian Rank, M.D., who is now with HealthPartners.

Bertram Kasiske, M.D., an HCMC nephrology staff member

since 1983, has been appointed chief of the Division of Nephrology. He also is a professor of medicine at the University of Minnesota Medical School. He succeeds Morris Davidman, M.D., who was recently named director of HCMC's internal medicine residency program.

Urologic Society President

The Minnesota Urologic Society has appointed Carl S. Smith, M.D., president for 1995-96. Smith is chief of the Urology Division, Department of Surgery, Hennepin County Medical Center.

Allina Vice President

Cardiologist David B. Pryor, M.D., has been named system vice president for information services at Allina Health System. In his new position, Pryor will oversee Allina's information systems and provide technological leadership.

Before joining Allina, Pryor was president of the New England Medical Center in Boston. In addition, he spent 15 years at the Duke University Medical Center, where he held a number of key positions, including director of clinical program development, chair of the Duke Medical Center information system advisory committee, and director of Duke's cardiology consultation service.

HMO Council Leaders

The Minnesota HMO Council has named Andrea Walsh to the new role of president for 1995-96 and John Hoefs chair. Walsh is senior vice president of policy and government relations at Minneapolis-based HealthPartners, and Hoefs is chief executive officer of Central Minnesota Group Health in St. Cloud.

ACR Honors

Seymour H. Levitt, M.D., of Minneapolis has been awarded the American College of Radiology Gold Medal, the ACR's most prestigious honor. Levitt, professor and head of the Department of Therapeutic Radiology/Radiation Oncology at the University of Minnesota Hospital for the past 25 years, has dedicated much of his professional life to ensuring that radiation oncology is recognized as a viable alternative treatment for many cancer patients. He has had significant influence on the acceptance of lumpectomy and radiation therapy as an alternative to radical mastectomy, according to the ACR.

Linda E. Bohn, M.D., of St. Paul, has been named a fellow of the ACR. Bohn, who practices at St. John's HealthEast and St. Paul Radiology, was selected for her outstanding contributions to radiology. She was one of 130 new fellows named by ACR's Board of Chancellors.

Fellowships are awarded to members for significant scientific or clinical research in radiology or important contributions to its literature. The criteria for selection include performance of outstanding service as a teacher of radiology, service to organized medicine, and an outstanding reputation among colleagues and the local community.

Nobel Prize Winners

Edward B. Lewis, a graduate of the University of Minnesota, has won the Nobel Prize for medicine with two other scientists for their research on how genes control early embryo development—information that should help

explain some birth defects and miscarriages. Lewis, 77, of the California Institute of Technology, graduated from the University of Minnesota in 1939 with a major in biostatistics. "As you can imagine, I'm overwhelmed. It's quite a shock. It's very nice, but actually what is more exciting is the science," Lewis said in a statement released by Caltech.

The other researchers are Eric F. Wieschaus, 48, of Princeton University, and Christiane Nuesslein-Volhard, 52, of the Max Planck Institute for Developmental Biology in Tübingen, Germany. Their research explains how a fertilized egg develops.

IHBB Recognition

The Indian Health Board of Minneapolis has awarded a certificate of appreciation to Lydia Caros, D.O., and her staff on the Fetal Alcohol Syndrome (FAS) Project for their efforts to help prevent FAS. Caros developed a comprehensive screening and surveillance program to identify and provide services to high-risk pregnant women and to children who have been exposed prenatally to alcohol. Services include screening of all pregnant women and of children exposed to alcohol, assessments and referrals for treatment, prenatal and parenting education, transportation services, and an outreach and case management program.

Places

Planned Parenthood Extends Services to Men

Planned Parenthood of Minnesota, traditionally a provider of reproductive health care for women, is now offering services for men. Starting this month, all 26 Planned Parenthood clinics in Minnesota and two in South Dakota will offer tests and treatment for sexually

transmitted diseases, HIV testing and counseling, and education on safer sex for men.

Originally, Planned Parenthood officials intended to study the response to such services for several months through pilot programs at clinics in Brooklyn Park and Bemidji, but the pilot programs were so successful that the organization decided to extend the program earlier than planned.

Planned Parenthood officials said they are expanding services to men because male reproductive health is not being adequately addressed. In addition, counseling and treating men for sexually transmitted diseases will benefit the agency's female clients, said Planned Parenthood spokesperson Diana Harvey in a *St. Paul Pioneer Press* article.

MDH Cuts Assistant Commissioner Positions

As part of a restructuring effort, the Minnesota Department of Health has reduced the number of assistant commissioners it employs from four to two. Since all four positions were vacant, the restructuring does not mean layoffs.

The Health Department's restructure combined four bureaus into two. One will oversee health systems and special populations, while the other will be responsible for general population programs, such as disease prevention and environmental programs.

St. Mary's and HealthEast Launch Parish Nurse Program

St. Mary's of the Lake Catholic Church in White Bear Lake is the first participant in HealthEast's pilot program for parish nursing. Bonnie Wek, R.N., will serve the congregation's health needs by conducting disease prevention, health promotion, and wellness efforts. She also will function as health educator and a trainer/coordinator of volunteers, and she will help parishioners examine the relationship between faith and

wellness. One of her first tasks will be to work with HealthEast to conduct a community needs assessment for the 2,400-household parish.

St. Mary's of the Lake worked with the HealthEast Wellness Program and the Spiritual Care Department of HealthEast White Bear Lake Care Center to establish this program, which is supported by a grant from the HealthEast Foundation. HealthEast hopes to expand the parish nurse program into more east-metro churches over the next few years.

Socioeconomics

Data Institute Releases Consumer Survey

The Minnesota Health Data Institute released results from its consumer survey on Minnesota health plans in a 16-page report distributed in early October. Among its findings, the survey showed that many Medicare and Medicaid plans have a high percentage of satisfied enrollees.

The survey compares customer satisfaction rates for 46 public and private health plans in such areas as getting appointments, having questions answered, and getting medical help by phone on evenings and weekends. Nearly 18,000 Minnesotans were interviewed for the \$1 million project, which is the first of its kind in the nation.

Although institute officials warned that the survey is designed for comparing plans of the same type, e.g., comparing two closed-network HMOs, preliminary results show that Minnesotans who receive care through HMOs are more likely to be satisfied than those in indemnity insurance plans. HMO members as a group, however, felt that their access to care was poorer compared with those who have traditional insurance. (The institute will try to

make such broad comparisons in a report scheduled to be finished this month.)

Among the plans with the highest percentage of satisfied consumers are the state's MinnesotaCare plan, Mayo Health Plan (network), SeniorCare (Medicare), Blue Plus Medicare, PHP+ Medicare, Medica Choice Care (Medicaid), Group Health Service (Medicare), and Medica Choice (point of service). Among the plans with the highest percentage of dissatisfied consumers are Metra-Health (point of service and indemnity), Minnesota Comprehensive Health (state program), MedCenters (point of service), NWNL (point of service), and State Farm (indemnity).

The 16-page report was distributed as a special advertising section October 6 in 60 newspapers statewide. Much of the information is also available on the Internet, at the following address: <http://www.mhdi.com/>.

Report Highlights Minnesota Health Plan Trends

The number of Minnesotans covered by self-funded health benefits plans increased sharply in 1994 as a result of large and small employers seeking alternatives to state-regulated health plans, according to the recently released "Minnesota Managed Care Review 1995," by Minneapolis-based consultant Allan Baumgarten. His sixth annual report analyzes key trends and issues in the Minnesota health care market.

The report, which provides detailed comparisons of health plans and analyzes the impact of market developments and state reform initiatives, says that Minnesota HMOs held down premium increases to their lowest level in recent years. Also of significance, the state's largest HMOs were not able to further reduce their average rates of inpatient hospital use.

HMO Report Analyzes National Trends

By January 1, 1995, nationwide enrollment in 562 HMOs reached almost 51 million, representing 19.4 percent of the U.S. population, up from 17.3 percent on January 1, 1994. This and other information on emerging trends in the HMO industry is provided in the 17th "Competitive Edge Industry Report 5.2" published by Minneapolis-based InterStudy Publications.

Five states accounted for almost half of the nation's net annual HMO enrollment gains: California, Texas, New York, Florida, and Pennsylvania. Ninety-one percent of HMO membership consisted of pure (traditional) enrollment, and open-ended HMO products constituted the fastest-growing segment of the industry in 1994, according to the report.

Specialty Physician Groups Create Partnership

Minnesota Specialty Physicians, Inc. (MSP) and East Metropolitan Health Organization (EMHO) have established a partnership involving 46 specialty groups and more than 420 physicians primarily in the Twin Cities metro area. The two groups plan several joint initiatives, such as developing clinical practice guidelines, said Tim Signorelli, chief executive officer of MSP. In addition, they plan to improve administrative efficiency by combining such business functions as group purchasing and contract support and management.

According to Signorelli, the groups will market services as a unit within the next five months.

United Way Opening School-based Clinic

The United Way of Minneapolis, working with the Hennepin Medical Society and Allina, is bringing health care to children who attend school at the Hans Christian Andersen complex in south Minneapolis through a

school-based clinic. Allina has provided a \$400,000 grant for the clinic.

The effort is part of United Way's Success by 6 initiative, which aims to help children achieve learning readiness at Andersen and other schools. The need for health care at the school is apparent; in just one day, the school nurse saw 60 kids. For many of the school's 1,400 children, 90 percent of whom come from poor families, the school nurse is their main access to health care. The initiative will also bring in social service agencies to work with families on problems that affect health.

Rates, Trends, Data

State Uninsured Rate Below National Average

Minnesota's rate of uninsured residents remained below average at 9.5 percent in 1994, compared with the national average of 15.2 percent, according to a new survey from the Census Bureau. About 428,000 Minnesotans are uninsured.

The survey, which questioned 60,000 households nationwide, including 800 in Minnesota, estimates that about 39.7 million Americans are uninsured, virtually the same as the bureau's 1993 estimate. States of the Upper Midwest had some of the lowest uninsured rates: North Dakota, 8.4 percent; Wisconsin, 8.9 percent; Iowa, 9.7 percent; and South Dakota, 10 percent. Other states with low rates include Vermont, 8.6 percent, and Hawaii, 9.2 percent. Texas had the highest rate at 24 percent, followed by New Mexico, 23.1 percent, and California, 21.1 percent.

Minnesota's uninsured rate traditionally has been among the nation's lowest.

Law & Policy

Caremark, Genentech Officials Acquitted on Kickback Charge

U.S. District Judge David Doty acquitted two executives and a former manager of Caremark International, an Illinois home health care company, and one executive of Genentech, a California drug company, on charges that they paid kickbacks to a Twin Cities doctor for prescribing a growth hormone made and administered by the companies. The physician, David R. Brown, M.D., still faces charges.

Acquitted were Judy Giel of St. Paul, a former manager of Caremark's Twin Cities office; James Mieszala of Kildeer, Illinois, and Joseph Herring of Libertyville, Illinois, both Caremark vice presidents; and Edmon Jennings, vice president of Genentech. In August 1994 they were indicted on charges that they conspired from 1986 to early 1994 to pay off Brown for prescribing Protopin, which is used to treat hormone deficiencies that stunt growth in children.

In a plea agreement this summer, Caremark pleaded guilty to mail fraud charges in Minnesota and Ohio and agreed to pay \$161 million in criminal fines and penalties to the federal government and the states. The company pleaded guilty to charges that its former subsidiary paid kickbacks to physicians who referred patients to its home infusion services.

Innovations

Mayo Discovers New Way to Image Objects

Mayo Clinic researchers have discovered a new method to image the mechanical properties of materials using a magnetic resonance imaging (MRI) scanner. The discovery is reported in the September 29 issue of *Science*.

The new technique, called

magnetic resonance elastography, applies sound waves to an object and generates an MRI image of the waves as they pass through the object. Just as waves in water are affected by piers and sandbars and other objects they pass, so too are sound waves—speeding up when passing through stiffer material, slowing down when passing through a more elastic substance.

The new technique reconstructs these images into a map illustrating the elasticity of materials within an object. The imaging method is so sensitive that it can detect acoustic vibrations smaller than the wavelength of light.

Richard Ehman, M.D., a diagnostic radiologist at Mayo Clinic and leader of the research team responsible for the report, said the new technique promises to have application in industrial testing, engineering, materials science, and acoustics. Mayo researchers are excited about its possibilities in medicine. "It may give us a powerful new tool for noninvasively characterizing tissue," Ehman said. "This new technique may permit 'palpation by imaging' in areas of the body where a doctor's hands can't reach." He speculates that it may have a role in detecting tumors of the breast, liver, kidney, and prostate.

This first report was based on research done on tissue-simulating materials and animal organs.

Medical Research

'U' Researchers Make Progress Against SCA1

University of Minnesota researchers report that they have transplanted the defective human gene for SCA1 into laboratory mice, a success that may eventually lead to a treatment or cure for hereditary ataxias.

Researchers began implanting the gene in mice embryos two years ago. They now have about 1,000 laboratory mice that carry the

defective gene, which they will use to determine how the gene weakens, damages, and kills brain cells in the cerebellum; when the damage begins; and what chemicals or other therapies might delay or prevent the onset of the symptoms.

SCA1 (spinocerebellar ataxia type 1) was originally known as Schut disease because it was identified among members of the Schut family, most of whom live in Minnesota, Iowa, North Dakota, and South Dakota. It was renamed when scientists discovered that it affects people outside the Schut family.

"This is very exciting," said Lawrence Schut, M.D., a Minneapolis neurologist and member of the Schut family, in the Twin Cities *Star Tribune*. He is medical director of the National Ataxia Foundation.

Flu Shots Benefit Working Adults

Vaccinating healthy working adults against influenza would save millions of dollars in lost work days and medical costs by reducing absenteeism and visits to the doctor, according to a report in the October 5 *New England Journal of Medicine* by a Minnesota research team. Traditionally, only the elderly and people with a chronic disease are urged to get a flu shot.

The researchers, led by Kristin Nichol, M.D., chief of the section of general internal medicine at the Minneapolis Veterans Affairs Medical Center, vaccinated 422 Twin Cities adults aged 18 to 64 and gave placebo shots to 424 adults. For those who were vaccinated, 25 percent had fewer respiratory infections during the flu season, between December 1, 1994, and March 31, 1995; 43 percent had fewer sick days because of respiratory infections; 36 percent had fewer sick days because of all types of illnesses; and 44 percent had fewer visits to physicians' offices for upper respiratory infections.

MM

MMA Sponsors Club

The Minnesota Medical Association wishes to acknowledge the following and thank them for their generous contributions to the 1994 Annual Meeting.

SUSTAINING (\$1,000 or more)



ASTRA MERCK



BlueCross BlueShield
BluePlus
of Minnesota



PATRONS (\$500)

3M Health Care



CURTIS1000

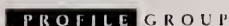
cycare



GLOBAL HOLIDAYS



OPPENHEIMER WOLFF & DONNELLY



Upjohn

CONTRIBUTORS (\$100-\$500)



PreferredOne

PIPER JAFFRAY

SCHATZ
PAQUIN
LOCKRIDGE
GRINDAL
& HOLSTEIN
Attorneys at Law

SB
SmithKline Beecham
Clinical Laboratories

STUTZMAN-HELLING
COMPANY


Whitesell
Medical Locums, Ltd.



Statement of Ownership, Management, and Circulation

(Required by 39 U.S.C. 3685)

1. Publication Title	2. Publication No.	3. Filing Date
Minnesota Medicine	3 5 1 9 - 0 0 0	10-15-95
4. Issue Frequency	5. No. of Issues Published Annually	6. Annual Subscription Price
Monthly	12	\$36.00

7. Complete Mailing Address of Known Office of Publication (Street, City, County, State, and ZIP+4) (Not Printer)

3433 Broadway Street N.E., Suite 300, Minneapolis, Hennepin County, MN 55413-1761

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer)

3433 Broadway Street N.E., Suite 300, Minneapolis, Hennepin County, MN 55413-1761

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Blank)

Minnesota Medical Association
3433 Broadway Street N.E., Suite 300, Minneapolis, Hennepin County, MN 55413-1761
Editor (Name and Complete Mailing Address)

Charles R. Meyer, M.D.

3433 Broadway Street N.E., Suite 300, Minneapolis, Hennepin County, MN 55413-1761
Managing Editor (Name and Complete Mailing Address)

Meredith McNab

3433 Broadway Street N.E., Suite 300, Minneapolis, Hennepin County, MN 55413-1761

10. Owner (If owned by a corporation, its name and address must be stated and also immediately thereafter the names and addresses of stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.) (Do Not Leave Blank)

Full Name	Complete Mailing Address
Minnesota Medical Association	3433 Broadway Street N.E., Suite 300
	Minneapolis, Hennepin County, MN 55413-1761

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check here. ☒ None

12. For completion by nonprofit organizations authorized to mail at special rates. The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes. (Check one)

☒ Has Not Changed During Preceding 12 Months

☐ Has Changed During Preceding 12 Months
(If changed, publisher must submit explanation of change with this statement)

PS Form 3526, October 1994

(See instructions on Reverse)

13. Publication Name	14. Issue Date for Circulation Data Below	
Minnesota Medicine	November 5, 1995	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total No. Copies (Net Press Run)	9,440	9,350
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales (Not Mailed)	-0-	-0-
(2) Paid or Requested Mail Subscriptions (Include Advertisers' Proof Copies/Exchange Copies)	8,957	8,959
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))	8,957	8,959
d. Free Distribution by Mail (Samples, Complimentary, and Other Free)	366	252
e. Free Distribution Outside the Mail (Carriers or Other Means)	50	51
f. Total Free Distribution (Sum of 15d and 15e)	416	303
g. Total Distribution (Sum of 15c and 15f)	9,373	9,262
h. Copies Not Distributed (1) Office Use, Leftovers, Spoiled	67	88
(2) Return from News Agents	-0-	-0-
i. Total (Sum of 15g, 15h(1), and 15h(2))	9,440	9,350
Percent Paid and/or Requested Circulation (15c / 15g x 100)	94.9	95.8

16. This Statement of Ownership will be printed in the November 1995 issue of this publication. ☐ Check box if not required to publish

17. Signature and Title of Editor, Publisher, Business Manager, or Owner

Date

Charles R. Meyer, M.D.

Editor-in-chief

10/3/95

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

NOVEMBER 1995

Nov. 9-10 **Changing General Surgical Practices 1995** St. Paul-Ramsey Medical Center; Mall of America Grand Hotel, Bloomington, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Nov. 10 **1995 Emergency Medicine Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Nov. 15 **Mastering Depositions and Testimony** Minnesota Medical Association and HealthVantage, Inc.; Minneapolis Marriott Southwest, Minnetonka, MN. CONTACT: Janyce Krohn, 777 NE Harding Street, #100, Minneapolis, MN 55413; 612/379-3393.

Nov. 16-18 **Strategies in Primary Care Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

DECEMBER 1995

Dec. 1 **Environmental Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Dec. 2 **Minnesota Obstetrical and Gynecological Society Fall Meeting** Minnesota Obstetrical and Gynecological Society; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/362-3737.

Dec. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Dec. 7-9 **Cardiopulmonary Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

JANUARY 1996

Jan. 8-12 **Bone and Soft Tissue Tumors** Mayo Foundation; Mauna Lani Bay Hotel, Kohala Coast, Hawaii. CON-

TACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

FEBRUARY 1996

Feb. 10-14 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 22-23 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 29-March 2 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1996

Mar. 7-8 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 22 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 28-29 **Critical Care 1996** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

APRIL 1996

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

JUNE 1996

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469

AUGUST 1996

Aug. 8-10 **Third Annual Symposium on Biomedical, Bio-pharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

OCTOBER 1996

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Phillips Hall, Siebens Building, Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

FAMILY PRACTICE OPPORTUNITIES

HealthPartners

HealthPartners offers excellent family practice opportunities for BC/BE family practitioners. HealthPartners, a staff-model HMO, offers its physicians excellent salaries, generous benefits, a balanced lifestyle with practice scheduling flexibility, and the opportunity to practice medicine without the headaches of managing an office.

The Family Practice Department is staffed by over 75 BC/BE physicians and offers a broad range of full-range and limited-range practice options.

To inquire about specific opportunities, please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Physician Services, Attn: Ann Mliner, 8100 34th Avenue South, PO Box 1309, Minneapolis, MN 55440-1309.

 **HealthPartners**

HealthPartners' mission is to improve the health of our members and our community.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., November 15 for January ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine, (oncology, pulmonology, and nephrology), family practice, ophthalmology, and ob/gyn. Excellent salary/benefits package includes guaranteed salary the first year with full partnership after one year; health, dental, and life insurance; pension/profit sharing; and relocation assistance. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Jonathan Cohen, M.D., MPH
Director, Urgent Care/Emergency Department (1110)
Veterans Affairs Medical Center
One Veterans Drive
Minneapolis, MN 55417
612-725-2158



An equal
opportunity
employer.

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: family medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates nine branch offices in southeastern Minnesota and staffs affiliate hospital emergency room. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (9/95-R)

Mankato, Minnesota: FP needed to join group of three board-certified family physicians and newly added part-time nurse practitioner and physician assistant in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare system

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine
Internal Medicine
Orthopedic Surgery
Noninvasive Cardiology
Neurology
Pediatrics

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; or call 800/438-3745.



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Filmore Street
Alexandria, MN 56308
612-763-5123

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441.

(*7/95-R)

Ski Steamboat Colorado: Three bedroom, three bath, non-smoking condo. Physician-owned. Sleeps eight. Washer/dryer, fireplace, heated garage, pool, sauna, hot tubs, cable TV, VCR, compact disc stereo. Free shuttles to lifts and town. Saturday to Saturday rentals, 612/427-8510.

*2-12/95

National Company Seeks Physicians—Contractor Basis: Immediate opportunity for licensed physicians in the Minneapolis/St. Paul area to complete insurance physicals on a part-time basis. Make your own hours; competitive pay. Contact Gretchen Michalski, 612/639-8133. 2-11/95

Internal Medicine: The Grand Forks Clinic, a 140-physician multispecialty group, is seeking an 11th internist. Clinic is a state-of-the-art facility, connected to a 350-bed acute-care hospital. Teaching and research available in affiliation with the University of North Dakota School of Medicine. Call Charles Matenaer at 800/611-2777.

*2-12/95

Internist...

Want to share call with 8 other Internists and live in the Brainerd lakes area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30-physician independent multi-specialty group
- Located in a primary service area of 40,000
- Almost 100% fee-for-service
- Excellent fringe benefits
- Compensation at least what the market pays
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Inquiries from Internists with subspecialty interest in Pulmonology and Rheumatology welcomed.

Call collect to administrator:

- Curt Nielsen
218-828-7105 or
218-829-4901
2024 South 6th Street
Brainerd, MN 56401



**COASTAL
PHYSICIAN SERVICES
OF THE MIDWEST, INC.**

Your Private Practice Alternative in the State of Minnesota



Red Wing ●

- No on-call
- Medical Directorships
- Assured Income
- Group Practice

Ed Kennedy
800-326-2782 • FAX: 314-291-5152

3221 McKelvey, Suite 106, St. Louis, MO 63044



**Park Nicollet Clinic
HealthSystem Minnesota**

Urgent Care Department

- BC/BE family practitioners, general internists, or emergency medicine practitioners
- Five positions available; twelve positions filled
- Varied and challenging patient population
- New flexible scheduling options

All considered full-time with same base pay

#1 40 hrs/wk, no evenings/no weekends

#2 36 hrs/wk, 6 hrs of evenings/weekends

#3 32 hrs/wk, 12 hrs of evenings/weekends

#4 28 hrs/wk, 18 hrs of evenings/weekends

- A 385 - physician multispecialty clinic
- Contact Patrick Moylan at 612/932-5986

or

- Send CV and letters of inquiry to:
Professional Practice Resources
Park Nicollet Clinic
6500 Excelsior Boulevard
St. Louis Park, MN 55426

or

- Fax 612/932-6490

Clarkson Family Medicine opened its doors July 1, 1991. We have filled in the Match Program every year since then and have expanded from a 12-resident program to an 18-resident program in 1995. We have seen our graduates, as a group, score in the top 10 percent nationally on the in-training exam. We currently have four full-time family practice faculty, one obstetrician, one pediatrician, and full-time behavioral science coverage, including two part-time psychiatrists. In order to provide the training necessary to prepare our residents for rural practice, including extensive obstetrics and procedural experience, we are recruiting two additional family physician faculty. Requirements include practice and/or teaching experience, strong obstetrics background, and a desire to participate in a new, exciting, and growing residency program. Responsibilities and salary are negotiable and based on experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants who use tobacco products. EOE. Send CV and/or letter of inquiry to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, NE 68131; 402/552-2045.

3-12/95

Attention: Internists and Psychiatrists: Immediate part-time positions available. Excellent pay and benefits—under *no contract*. Call 800/295-6373 for additional information.

1-11/95

Family Practice: The Grand Forks Clinic, a 140-physician multispecialty group, is seeking an additional family physician at its main clinic and at one of its nearby branch offices. Teaching and/or research are readily available at the University of North Dakota Medical School with family practice residents and medical students. Call Charles Matenaer at 800/611-2777, or fax CV to 414/784-0727.

*2-12/95

Medical Director: Interstate Medical Center, affiliated with the University of Minnesota Health System, is a 36-physician multispecialty practice located one hour southeast of the Twin Cities and an hour northeast of Rochester, and is nestled in the bluffs along the beautiful Mississippi River. We are seeking a practicing physician for 50 percent practice, 50 percent medical director duties. Requirements for this position include BC/BE, Minnesota license, minimum one year administrative experience preferred. Competitive salary and benefits package. Respond with a CV or telephone call to Karen Fredrickson, Administrative Assistant, Interstate Medical Center, Highway 61 West, Red Wing, MN 55066; 612/385-4201.

2-11/95

University of Minnesota, Boynton Health Service—Clinic Physician/Psychiatrist: The Mental Health Clinic at the University of Minnesota Boynton Health Service will have a full-time position for a clinic physician-psychiatrist starting January 1, 1996. Boynton Health Service is a large,

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.



Columbia Park Medical Group

- **Family Practice** ● **Internal Medicine**
- **Occupational Medicine** ● **Pediatrics**
- **BC/BE Specialists**

FAMILY PRACTICE: Join group or do Urgent Care with a 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Nine-member department has busy hospital and clinic practice.

OCCUPATIONAL MEDICINE: Three B.C. physicians looking for additional physician to join busy Occupational Health Department.

PEDIATRICS: Seeking fourth pediatrician interested in primary and consultative pediatrics.

Columbia Park Medical Group is a physician-owned multi-specialty group. The 60-physician practice is in three sites located in the Northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Tom Behrend, (612) 586-5882

multifaceted, public health clinic serving students, staff, faculty, and alumni on the University of Minnesota campus. Applicants must be board eligible or certified in psychiatry and licensed to practice in Minnesota. Two years experience as practicing psychiatrist in outpatient setting. Maintenance of program of professional improvement. Effective communication skills. Demonstrated good relationships with clients and colleagues. Experience in outpatient work with a college population would be welcomed. Salary will be consistent with academic health service settings. Excellent benefits. Please send CV by November 30, 1995, to David Heiberg, Ph.D., Chair, Boynton Health Service, 410 Church Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. *1-11/95

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE. 3-12/95



NORTHERN EXPOSURE

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park. It's setting is not as remote as the popular television series, but you will be exposed to your share of wildlife, lakes, streams and a lot of friendly people working in a 30-physician, multi-specialty clinic — natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd. currently has openings in **Family Practice, Internal Medicine, Orthopedics, and ENT**. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:

East Range Clinics LTD



Bill Doran, Physician Recruiter

910 Sixth Avenue North, Virginia, MN 55792 1-800-377-3290 or 218-741-0150

Child Psychiatrist

Had it with managed care and interested in practicing community-based psychiatry? Full and part-time opportunities to join a multi-disciplinary team dedicated to supporting family strengths. Diverse client population. Includes evaluations, medication services, consultation and psychotherapy treatment options. Must be board eligible or certified. Located in Minneapolis, a livable urban community with abundant cultural and recreational activities.

For immediate consideration, you are invited to reply with your CV and salary requirements to:

Hennepin County Human Resources Department
Attn: Dave Waage
A-400 Government Center
300 South Sixth Street
Minneapolis, MN 55487
(612) 348-7593



WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

GENERAL SURGEON —BE/BC—

The Department of Surgery at the Mayo Clinic, in conjunction with the Fairmont Clinic, is seeking two broad-based general surgeons to join a Mayo Regional Facility in Fairmont, Minnesota, 120 miles west of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 15-person Mayo-affiliated medical clinic in this town of about 11,000 with a 77-bed hospital and a service population of 45,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise, and excellent salary and benefits. Inquiries:

Michael G. Sarr, M.D.
Department of Surgery
Mayo Clinic
Rochester, MN 55905

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Orthopedic Surgeon—Illinois: St. Joseph Medical Center, Bloomington, a member of OSF HealthCare, is recruiting for a general orthopedic surgeon for this fast-growing college community. Bloomington/Normal, population 130,000, is experiencing tremendous growth and affluence as young families move in to take jobs with State Farm, Illinois State University, and other major employers. The physician will share call with another solo orthopedic surgeon; the position offers excellent salary and benefits package. We invite you to consider this outstanding practice opportunity by contacting Dawn Hamman, OSF HealthCare, Saint Francis, Inc., 4541 North Prospect, Peoria, IL 61614; phone 800/438-3740; fax 309/685-2574. 3-1/96

Fully Credentialed FPs and IMs available for part-time positions in urgent care, ER, clinics, or hospital settings. Call 800/295-6373 with your need. 1-11/95

NOVEMBER 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	76
Aspen Medical Group.....	65
Audio-Digest Foundation	Cover 2
Brainerd Medical Center	77
Central Minnesota Group Health Plan	60
C.F. Anderson Co., Inc.	61
Chisago Health Services	74
CNA Insurance	25
Coastal Physicians	77
Columbia Park Medical Group	78
East Range Clinics	79
Emergency Practice Associates	80
Fairview Clinic Services	34
Fargo Clinic MeritCare	57
Gillette Children's Hospital	61
Global Holidays	39
HealthEast	Cover 4
HealthEast Capitol Medical Laboratory	65
HealthPartners	3, 74
Hennepin County	79
Mayo Foundation	80
Medical Protective Company	Cover 3
Midwest Medical Insurance Co.	40
Minnesota Medical Business Resources	4, 66
Minnesota Physicians Insurance Agency	57, 58
Moonlight Home Health Care	78
Multicare Associates of the Twin Cities	39
North Memorial Medical Center	3
Norwest Center	39
Oxboro Clinics	79
Park Nicollet Medical Center	77
St. Francis, Inc.	76
THC Minneapolis	14
Veterans Affairs Medical Center—Minneapolis	76
Wenatchee Valley Clinic	65
Whitesell Medical Locums, Ltd.	24

EMERGENCY MEDICINE P • S • I • T • I • N • S

IOWA

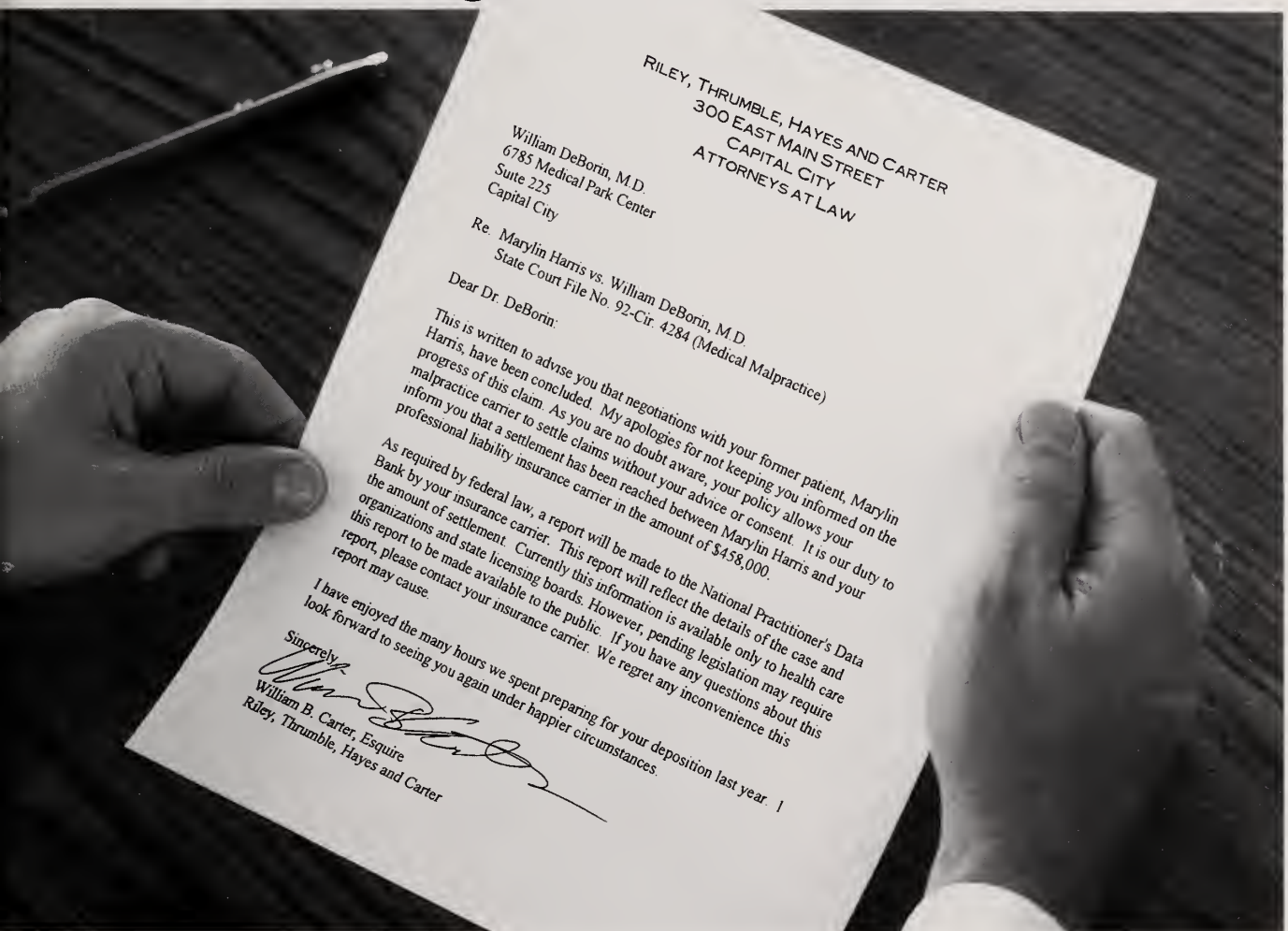
NORTH & CENTRAL MINNESOTA

- Full- and part-time
- Comprehensive benefit packages
- Paid malpractice
- Professional environments
- Ample time for family and leisure
- Progressive physician-owned group
- Excellent compensation packages
- Various locations
- Reasonable housing in safe communities
- Top-notch school systems
- Quality lifestyles

CALL 1-800 458-5003

Emergency Practice Associates
or send CV to Sheila Jorgensen
P.O. Box 1260, Waterloo, IA 50704

Medical Protective Policyowners NEVER get letters like this!



Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--no strings attached! In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation.

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Serving the Health Care Community Exclusively Since 1899

A+ (Superior) A. M. Best
AA (Excellent) Standard & Poor's

800/344-1899



FREEDOM CAN BE AS SIMPLE AS BREATHING

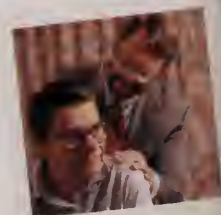


WE SPECIALIZE IN RESTORING THAT FREEDOM.

Faced with the probability of lifelong ventilator dependency, patients are experiencing a program of intensive care, where many of the unweanable are weaned, and the focus is on gaining independence.

Created specifically to care for patients with chronic ventilator or oxygen dependency, the Prolonged Respiratory Care Unit (PRCU) at HealthEast Bethesda Lutheran Hospital and Rehabilitation Center has gained national recognition through advanced aggressive therapy.

But most importantly, our patients have gained their freedom.



For more information
Call 1-800-566-2720

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

Scope of services: General Medical Services • Ventilator/Respiratory Care • Wound Care • Neurobehavioral Services • Rehabilitation Inpatient Services
Swallowing Disorder Treatment • Capitol Heights Respiratory Residence • Geriatric Behavioral Care • Pain Management at the **Minnesota Pain Center**
(MPC), located at HealthEast Bethesda Lutheran Hospital and Rehabilitation Center, 559 Capitol Boulevard, St. Paul, MN 55103

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

Inside The Monitor:
Medicare • Medicaid • BHCAG



TEACHING
By EXAMPLE

DECEMBER 1995

WEBB FINANCIAL GROUP

INVESTMENT ADVISORS



LeAnn Lenander, CFP Les Webb Jerry Webb, CFP

Webb Financial Group has over 44 years in combined investment experience.

We are recognized as a leader in managing low to moderate risk
NO-LOAD FUND portfolios for individuals and retirement plans.

We primarily work with portfolios of \$200,000 or more.

Our mission is to help our clients achieve their investment and income objectives,
while maintaining a long term safe haven for their assets.

Call a personal investment advisor at
Webb Financial Group for a no-cost, no-obligation consultation.

9 2 5 - 9 2 6 1

8 0 0 - 9 2 7 - 9 3 2 2

A Registered Investment Advisor
6600 France Avenue South, Edina, MN 55435

APR 12 1996

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Duluth family physician Carol Farchmin, M.D., instructs first-year medical student Shara Johnson. Cover photo by Jeff Frey.

DEPARTMENTS

- 2 MEDIA WATCH
- 5 EDITOR'S NOTEBOOK
- 26 AUTHOR INSTRUCTIONS
- 47 NEWS CLIPS
- 55 CME IN MINNESOTA
- 57 CLASSIFIED ADS
- 62 INDEX TO ADVERTISERS
- 63 1995 INDEX

FACE TO FACE

- 6 MAY THE BALANCE BE WITH YOU** Howard Bell
Byron Crouse, M.D., director of family practice at the UMD School of Medicine, teaches students to balance work with play.

PERSPECTIVES

- 8 THE SURPRISE VISIT** Harrison Farley, M.D.
The Minnesota Twins lost the '65 Series, but one fan's baseball hero came through when he was needed most.

COVER STORIES

- 10 OUT OF THE CLASSROOM—INTO THE EXAM ROOM** Howard Bell
UMD School of Medicine's formula for success calls for pairing students with rural physicians in an innovative mentoring program.
- 17 UNIVERSITY OF MINNESOTA COMMUNITY ROTATIONS EXPOSE STUDENTS TO FAMILY PRACTICE** Daniel P. Benzie, M.D., and Susan B. Frericks
As health care is shifting to outpatient and preventive medicine, so, too, is medical education.

CLINICAL & HEALTH AFFAIRS

- 21 RETIREMENT OF SENIOR PHYSICIANS IN RURAL MINNESOTA: FACTORS INFLUENCING PHYSICIANS' PLANS TO RETIRE** Julia Lee, B.S., Thomas Lenzmeier, B.S.E., James Boulger, Ph.D., Sally Buck, M.S., Dale Bergeron, M.A., and Terence J. Hill, M.P.A.
- 27 LIFE AFTER MEDICAL PRACTICE: A RETIREMENT PROFILE OF MINNESOTA PHYSICIANS** ... Harold C. Seim, M.D., M.P.H., and James E. Mitchell, M.D.
- 31 LAPAROSCOPIC-ASSISTED HYSTERECTOMY IN A RURAL MINNESOTA HOSPITAL** Charles A. Tietz, M.D., F.A.C.O.G.

SPECIAL REPORT

- 43 THREE TO GET READY: TAKING EDI FROM THEORY TO REALITY** Sue Chapin-Strike
Implementing an EDI system takes knowledge and planning. These steps will help get you going. Last of three parts.

33 *The Monitor*

HIGHLIGHTS What will Medicare and Medicaid cuts mean to Minnesota? • BHCAG introduces direct contracting



When the Numbers Don't Add Up

The headline read, "Postmenopausal Estrogen Use Linked to Breast Cancer." My estrogen-taking patient nervously unfolded the clipping and said, "This article says that 70 percent of women taking estrogen will get breast cancer."

Although I'm only a B+ newspaper skimmer, I was sure that wasn't what I had read. The disturbing article described a June 15 *New England Journal of Medicine* report derived from the Harvard Nurses' Health Study. The paragraph that caused my patient's concern said: "Among the women studied who were 60 to 64 and who naturally have a higher rate of breast cancer than women in their 50s, current use of hormone replacement was associated with a 70 percent increase in the risk of breast cancer for reasons researchers cannot explain." My patient got the number right, but what the number meant was quite different from her interpretation.

Medicine and the media have two giant problems with educating people about medical topics—medicine and numbers. Long notorious for being polysyllabic, medicine has barely crept out of the medieval, mystical mire in explaining its intricacies to the laity. We fall far short in our duties as translators of medicalese. I plan to focus on translation in a future column. Numbers are the topic here—how they're used to advance medical knowledge and how they can be misinterpreted if not seen in clear context.

The medical profession is fueled by numbers. Physicians and paramedical personnel are chosen

by medical education institutions, in part, for their proficiency at mathematics. At our training table, we ingest formulas, dosages, and measurements that we use daily in practicing medicine. But much of the nonmedical community hasn't dined at the same table. The closest many of our patients have gotten to statistics is the Dow Jones or the baseball box score.

Reading a "70 percent increase" as "70 percent of patients" is an example of what John Paulos termed "innumeracy," misinterpreting the meaning of numbers. In fact, what the *NEJM* article actually said was that the group that used postmenopausal estrogens had a relative risk of 1.7. I don't fault the reporter for avoiding that term, which has all the specificity of my teenager's "whatever." However, I do think the report could have spelled out the results to provide a more understandable perspective.

The author also missed the opportunity to place this study in a wider context—to reveal to the public the crawl of scientific knowledge. Despite the media's need for "breakthroughs" and "miracles," medical understanding rarely expands by giant leaps. Instead, it lurches mostly forward, taking uneven, almost ataxic, steps. Multiple studies of one issue are required to even approach consensus. The article on postmenopausal estrogens and breast cancer gave scant attention to the many past studies that contradicted the estrogen-breast cancer connection. Indeed, a few weeks after this article appeared, another newspaper piece reported a study that found *no* relationship between postmenopausal estrogen use and breast cancer. The public needs to

repeatedly hear, and the media needs to repeatedly say, that individual medical studies are rarely the final word.

So how did I answer my patient's concern? I first cited the near-equal number of studies claiming no estrogen-breast cancer link. Then, with trepidation born of math anxiety, I launched into an illustration of a relative risk of 1.7: "Look at 100 women of a certain age who have not taken postmenopausal estrogens and see how many have had breast cancer. Let's assume it's 10. Look at 100 women of the same age who have taken postmenopausal estrogens. If this group has a relative risk of 1.7, then 17 women in this group will have had breast cancer." I apologize to all statistical gurus among our readers for this simplistic picture, but I think it's basically right.

Can a newspaper be expected to do this? Aren't such concepts beyond the space and complexity limitations of a newspaper? I think not. Newspapers can report RBIs and ERAs without explanation because they assume their sports readership has a certain baseline of knowledge. Similarly, they can assume business-page readers know the basics of the stock quotes. They cannot, however, assume the newspaper-reading public understands the subtlety of statistical analysis of medical studies. Just as newspaper readers require historical background to fathom the Bosnian conflict, and meteorological concepts to understand hurricanes, they need statistical tutoring to know which medical studies are important. The public needs educating. The medical community and the media need to do it. Otherwise, we

condemn our readers and our patients to eternal innumeracy. **MM**

"Media Watch" is an occasional column written by Minnesota Medicine's editor-in-chief, Charles Meyer, M.D., an internist with Consultants-Internal Medicine in Minneapolis.

Correction:

The original Table 3 published with the article "The Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota" (September 1995, page 29) listed incorrect figures for the number of gunshot wounds and the rate of gunshot wounds per 100,000 population for the category "Mpls-all zips." The following table is correct.

Table 3

*Prevalence rates for 1994
Minneapolis high-injury zip
codes*

Zip	Population*	#F & NF GSW†	GSW/ 100,000
55404	19,903	46	231.1
55407	34,059	36	105.8
55408	29,658	27	91.2
55411	30,088	78	263.3
Mpls- All zips	368,000	314	85.3

*The sourcebook of zip code demographics. 8th ed. Arlington, Virginia: CACI Marketing Systems, 1993.

†Hospital only data. Does not include Vital Statistics data, e.g., suicides, DOA.

Simply put...

We represent a wide spectrum of practice options in the Minneapolis/St. Paul area. Our desire is to help you find a challenging and rewarding opportunity in which your personal ambitions can be fully realized. *—and that's not a line, it's a promise.*

Opportunities now available for board-certified/ board-eligible physicians:

- Family Practice
- Obstetrics/Gynecology
- Internal Medicine
- Otolaryngology
- Occupational Medicine
- General Surgery



Fairview

Contact: Physician Placement Department
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420

612-885-6224 1-800-842-6469

E-mail: fvrecruit @ aol.com



Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical
Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, 612/378-1875. The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription—\$40. Single copies—\$3.50. Canadian—\$70. Foreign—\$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Chris P. Tountas, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1995. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Second-class postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1995-96 Officers

President
Michael J. Murray, M.D.
President-Elect
Raymond G. Christensen, M.D.
Chair, Board of Trustees
Timothy J. Crimmins, M.D.
Vice President
Paul R. Hamann, M.D.
Secretary
Judith F. Shank, M.D.
Treasurer
Erick Reeber, M.D.
Speaker of the House
Anthony C. Jaspers, M.D.
Vice Speaker of the House
Blanton Bessinger, M.D.
Past President
Andrew J. K. Smith, M.D.
Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Nancy MacKenzie

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.
N.E. District
James L. Anderson, M.D.
Jack B. Greene, M.D.
N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.
West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Joseph M. Tombers, M.D.
East Metro
Joseph L. Rigatuso, M.D.
Kent S. Wilson, M.D.
S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.
S.E. District
Peter Amadio, M.D.
David C. Herman, M.D.
Noel R. Peterson, M.D.
Resident Member
Scott Stafford, M.D.
Medical Student
Timothy Olson

AMA

AMA Trustees
William E. Jacott, M.D.
AMA Delegates
Robert D. Christensen, M.D.
E. Duane Engstrom, M.D.
A. Stuart Hanson, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Thomas A. Stolee, M.D.
Richard B. Tompkins, M.D.,
Chair
AMA Alternates
Theodore L. Fritsche, M.D.
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.
Chief Financial Officer
George C. Lohmer Jr.
Director of Legislation and Public Policy
David Renner
Director of Communications
Mark S. Vukelich

Teaching by Example

Charles R. Meyer, M.D.

Example is not the main thing in life—it is the only thing.

—Albert Schweitzer

Few things are harder to put up with than the annoyance of a good example.

—Mark Twain



“We need more mentors teaching art and attitude to doctors-in-training.”

Medical education is a bumpy road. Whether it gets emerging physicians where they want to go without causing psychological whiplash depends largely on the teachers that trainees encounter along the way. We learn from books, but we grow by example. Attitude is as important as aptitude. More than many professions, medicine has long recognized the importance of hands-on training. Years three and four of medical school, internship, and residency are the “see one, do one, teach one” model of education.

Historically, the traditional high-tech, university-affiliated medical school has slanted this experience. Students saw lots of porphyria and pediatric cardiologists and few pneumonias and family practitioners. Small wonder that the number of medical school graduates heading for primary care careers dwindled in the '80s. Now, government, third-party payers, and patients are calling on the medical education establishment to reverse this trend before the millennium. This month's *Minnesota Medicine* features two University of Minnesota programs that are answering that call. Both put students out in the community to learn by example about the kind of medicine they're likely to practice.

Our cover story describes the University of Minnesota–Duluth School of Medicine's rural preceptorship program for first- and second-year

students. The successful program was supplying primary care physicians to the medical care system before anyone knew it needed so many.

Daniel Benzie, M.D., describes a new program that places third- and fourth-year students from the university's Minneapolis and Duluth campuses in community rotations in Duluth, introducing them to medical practice in outpatient clinics and community hospitals.

Veterans (victims?) of traditional teach-by-intimidation medical training will marvel at the Duluth approach. Abandoning the elitist mentality that only medical center docs should teach, the programs expose medical students to community physicians. Recognizing that illness-focused, hospital-based training is less important in our resource-sparse economy, they stress outpatient care and teach wellness and preventive practice. Believing that medical practice is fun, UMD preaches and practices balance in life, informality, optimism, and collaborative learning and working—a welcome breath of

fresh Superior air.

Years ago, I was one of many private attendings doing teaching rounds with residents three days a week at Hennepin County Medical Center. Repeatedly, residents told me they liked the exposure to community physicians with their different approaches to problems and their revelations about private practice. Recently, my three-doctor group had first-year University of Minnesota medical students observing in our office and a fourth-year student seeing patients. We may not teach the intricacies of the corticospinal tract, but we do teach. Between patients—in what I call hallway pearls—we teach the science: the differential diagnosis of dizziness and where to listen for a murmur. But most important, we teach the art: how to greet patients, how to establish rapport, how to question completely yet efficiently, how to support and counsel, and how to pan the gravel from a mass of data to find the golden diagnosis. Most of this we don't articulate; the students see it happen.

If medicine is going to meet America's primary care needs, we need more mentors teaching art and attitude to doctors-in-training.

I have a quote posted in my office by Charles Swindoll that reads: “The longer I live, the more I realize the impact of attitude on life. Attitude, to me, is more important than the past, than education, than money, than circumstances, than failures, than successes, than what other people think, say, or do. It is more important than appearance, giftedness, or skill. ... We cannot change the inevitable. The only thing we can do is play on the one thing we have, and that is our attitude. ...”

I suggest sharing the quote with a medical student.

MM

MAY THE BALANCE BE WITH YOU

Two ring-necked pheasants fly eternally over Dr. Byron Crouse's desk in tribute to his philosophy: Balance work with play. University of Minnesota-Duluth medical students who prefer fairways to pheasants know Crouse as the guy who organizes sunrise golf games in Duluth's dewy dawns. Students who prefer fish to fowl know of his line-wetting expeditions to the Boundary Waters or maybe just a quick fish in a nearby lake. Then it's time to study medicine. "We show students that physicians are happy," says Crouse. "We show them that where they're headed is upbeat and positive."

In his 18 months directing the UMD School of Medicine's Department of Family Practice, Byron Crouse has retooled the curriculum to reflect managed care and the capitated realities of practicing medicine. He created the department he now heads and has more than doubled the department's physicians and staff. He's expanded the department's single stream of funding into a small delta of sources. He's helped department faculty organize clerkships for third- and fourth-year students at the Minneapolis campus so they can spend four weeks with a

*BYRON CROUSE, M.D.,
DIRECTOR OF THE UMD
SCHOOL OF MEDICINE'S
DEPARTMENT OF FAMILY
PRACTICE, HAS A PHILOSOPHY HE SHARES WITH
STUDENTS: BALANCE
WORK WITH PLAY.*

physician in an ambulatory, rural setting (see related article, page 17). He has first- and second-year students conducting practical research. He's arranging a way for the medical school to share facilities with the College of St. Scholastica's Nursing School.

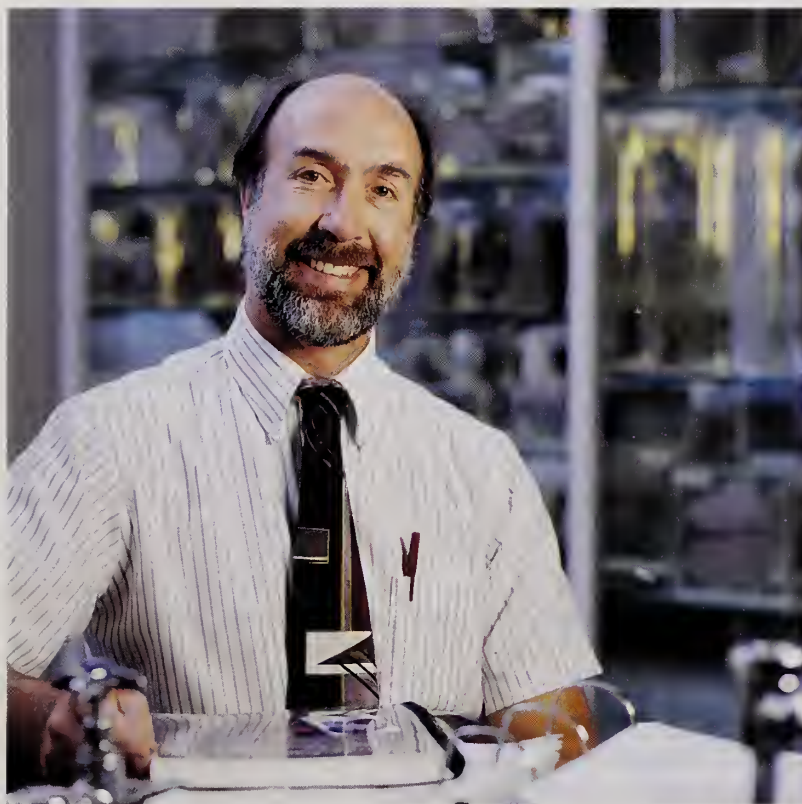
"He's done all of this in a very open, gregarious, positive manner," says Ron Franks, M.D., the school's dean. "He's a tremendous colleague who suffers from pathological optimism."

Byron Crouse is a North St. Paul native who completed his pre-med course work at St. Olaf College in Northfield, Minnesota. He earned his medical degree

at the Mayo Medical School and completed his family practice residency in Duluth, then entered private practice in Spooner, Wisconsin. Crouse says he's always liked teaching, but his interest jelled during his seven years in Spooner. "I supervised family practice residents in an ambulatory setting and found I liked it," he says. "In Spooner, the issues and needs of rural family medicine became apparent to me."

In 1986, Crouse became assistant director of UMD's Family Practice Residency Program. "I want-

BY HOWARD BELL PHOTO BY JEFF FREY



Byron Crouse, M.D., director, University of Minnesota–Duluth School of Medicine Department of Family Practice.

ed to bring my enthusiasm for rural health care to students and residents,” he says. “I wanted them to see that rural practice does not mean providing second-class care. If anything, the care can be better, and you have to be more innovative and creative.” Crouse oversaw residents’ patient care and encouraged them to practice collaboratively. “Working with others is part of being a good doctor and part of being a good teacher,” he says. “In a rural setting, you can handle 40 percent of situations on your own. Sixty percent require a team. No one of us is smarter than all of us.”

Tom Day, M.D., who directs the residency program, says Crouse brought his knowledge of private practice into the educational setting. “He keeps medical education at a practical level, and he exemplifies for the residents balance between the doctor’s professional role and the doctor’s personal needs,” says Day.

Crouse accepted his current position at UMD in

1994. He saw that the school had tremendous opportunity for growth because managed care casts family practice in the so-called gatekeeper role. “University of Minnesota–Duluth has always had a strong family practice mission since its inception,” says Crouse. “And we’ve always had a high percentage of graduates opting for rural practice.”

Shortly after becoming director of UMD’s Family Practice Department, Crouse applied his knack for collaboration to changing the Family Practice Residency’s affiliation from the University of Minnesota in Minneapolis to UMD. Now residency program funding comes directly to UMD instead of being channeled through the Minneapolis campus. Functionally, things remain the same. “I’m really proud ... that the change occurred without any problems,”

he says. “Now we have more local control, more accountability for funds, and more support for the program.” University of Minnesota–Duluth students transfer to the Minneapolis campus to complete years three and four. “I think the two schools share a complementary philosophy, and we definitely work well together,” he says.

Crouse says UMD’s faculty bring practical day-to-day medical practice into the classroom. Duluth has no university hospital or clinic. “Historically, this was seen as a weakness,” Crouse says. “‘How can you have academic rigor?’ people would ask. A good medical education used to mean getting accepted into the biggest program with the biggest hospital, where you’d see a variety of sick people. Today, health plans hire physicians who know how to keep patients healthy. The emphasis is on health and wellness. Increasingly, a university hospital setting

CROUSE continued on page 53

The Surprise Visit

Mr. Nelson appeared healthy when he entered my surgical office for the first time. My initial impression was that, in his prime, he might have been a pulling guard in football or perhaps a baseball catcher, for he had the physique of an Ernie Lombardi. He was outwardly jovial, but underneath this cover, he had serious complaints. Inside his powerful frame a lethal cancer was growing. He had been a robust eater over the years, but his appetite had diminished during the preceding months. He became uncomfortable if he tried to consume his usual amount of food. His weight began to plummet.

In other respects he was fine. He had no pain and said that other than the fullness in his belly, he felt great for his 70 years. He was the owner of an advertising agency, and he enjoyed the pleasures of golf and cross-country skiing, but his greatest passion was baseball. Oh, how he loved those Minnesota Twins! He had seen every home game since Calvin Griffith moved his team from Washington, D.C., to the Twin Cities. He watched the games from the vantage of marvelous box seats behind first base. He would endlessly recount stories about his heroes of the baseball diamond.

The pallor of his conjunctiva betrayed an anemia. I discovered a large ominous left cervical node, a pathological finding that signaled the possible spread of an intra-abdominal cancer. Indeed, tests revealed his tumor to involve virtually his entire stomach. I offered no cure but a period of palliation if a debulking procedure could be accomplished, followed by chemotherapy.

It was the spring of 1965, and Mr. Nelson had high hopes for his Twins that year. Spring training would soon be over, and he wanted to miss as few games as possible once the regular season began. He

*The Minnesota
Twins lost the '65
Series, but one fan's
baseball hero came
through when he
was needed most.*

By Harrison Farley, M.D.

was anxious to get on with his treatment.

Surgery revealed a large tumor with liver and nodal metastases requiring a gastrectomy and a stomach pouch made from the small intestine. His weight stabilized once he could eat again (albeit in small portions). He was given what chemotherapy

we had available at the time, and he regained much of his strength. Despite two bowel obstructions that summer, Mr. Nelson rallied and returned to his box seat.

In the last few weeks of Mr. Nelson's life, the Twins' quest for an American League title became a consuming diversion. He concentrated on their day-to-day progress. They were heading for a championship, doing great, even as Mr. Nelson's health was declining.

We didn't talk much about his cancer anymore during his office visits. We both knew what was happening. Instead, we talked about Harmon's injury, or Bob Allison's homers, or "Mudcat" Grant, or Jim Kaat, or Zoilo Versalles. But Mr. Nelson's No. 1 hero was Tony Oliva. Mr. Nelson would edge forward on his seat when he talked of Tony, a left-handed hitter, lining one of his rocket shots off the wall or into the seats. His face expressed pure joy. Never had he seen a batter stroke a ball like Tony!

Mr. Nelson's health began to fail about the time the Twins lost the World Series to the Dodgers (and to the arm of Sandy Koufax). It seemed Mr. Nelson had held on just to witness the Series. In the days that followed, his weight fell precipitously, and he became discouraged.

There was fresh snow on the ground when Mr. Nelson was admitted for the last time to Swedish Hospital. Winter had descended on Minnesota. Mr. Nelson's room became increasingly morose, and we had only brief discussions of his very real aches and

pains. As a young surgeon, I wasn't very adept at helping patients deal with impending death.

On a particularly gray and gloomy day, I could tell from the trend of Mr. Nelson's vital signs that his suffering would soon be over. I walked to his room with a heavy step, but I was in for a surprise. His nurse met me at the door and said, "Doctor, Mr. Nelson has something to show you!"

The overhead light was dim, and Mr. Nelson lay quietly on his back. He recognized me and painfully worked his way up onto his elbows so he could look me in the eye. A great smile came across his face. The gloom had lifted. His voice was weak but spirited.

"Doctor, guess who came to see me last night?" he said. I shook my head, for I had no idea who could provoke such a reaction.

"Hand me that ball," he said, pointing to the countertop.

A gleaming new baseball rested prominently between vases of flowers. I picked it up and read the inscription, "To a great fan, Tony Oliva."

"Can you imagine Tony coming here to see me last night, Doctor?"

Later, I would discover that Mr. Nelson's nurse was a friend of the baseball star's wife, and when Tony heard of Mr. Nelson's plight, he offered to visit him in the hospital.

My patient lay back on his pillow, holding the baseball in his hands, a twinkle in his eye and a look of contentment on his face. He died later that afternoon.

Years later, I sat in the airport terminal waiting for a visiting relative. Now an established surgeon and in the prime of my life, I was, quite frankly, rather satisfied with myself. As I sat idly glancing at the passersby, my eye fixed upon a familiar figure walking laboriously up the ramp, carrying a duffel bag.

A buzz of excitement passed from person to person in the waiting area. Although long past his prime, the approaching man was still handsome and very well-known in

Minnesota. Several of us stood for a better view. The man's knees were in marked varus position from too many injuries and too many operations. I had no trouble identifying Tony Oliva.

I asked my wife to hold my seat and, along with several kids, I raced forward to block his path. He set down his bag. Tony was only a batting coach and unlikely to make the Hall of Fame because his career was cut short by injury. Yet, I'd witnessed this guy hit a ball so hard off Yankee Ryne Duren that it traveled six feet off the ground all the way to the center field wall without dropping. I wanted to thank him for that long-ago visit to my patient, but when it was my turn in line, I was tongue-tied.

"Autograph?" he asked.

I'd lost my cool. I searched my pockets. All I could find were a parking ticket and a blank envelope. I thrust the envelope and my pen at him.

"Can I get your signature, Tony?" I blurted.

He looked at me quizzically.

"For my son," I said, a bit sheepishly.

"Sure," he said, with a knowing smile.

MM

Harrison Farley is a retired general surgeon living in Cannon Falls, Minnesota.



TIMOTHY HOULE

Out of the classroom—

Into the Exam Room

By Howard Bell

PHOTOGRAPHS BY JEFF EREY

The UMD School of Medicine's formula for success calls for pairing first- and second-year students with rural physicians in an innovative mentoring program.

Jim Boulger knows it's October 16 without looking at a calendar. The University of Minnesota–Duluth's first-year medical students are dressed nicely and are acting panicky—they're about to spend their first half-day with their preceptors, family physicians in the Duluth/Superior area. "What do I do?" one student asks Boulger, who's directed UMD's preceptor program for 21 years. "My doc's on vacation!" He tells her the real world doesn't follow the university schedule. You get the day off.

The University of Minnesota–Duluth preceptor program gets medical students out of classrooms and into exam rooms. It's a big reason why UMD has received recognition and numerous awards for curriculum innovation and why a high percentage of its grads pursue family medicine careers. It's a big reason why two-thirds of alumni showed up at a recent all-class reunion. And it's a big reason most alumni surveyed think of themselves as UMD grads first, University of Minnesota grads second.



Since the UMD School of Medicine's first class graduated in 1976, 52 percent of its students have gone into family medicine, compared with 11 percent nationally. Of students who train all four years in Minneapolis, 19 percent enter family practice. But don't think for a moment the two campuses are rivals. "Minneapolis has a superb program," Boulger says. "In sheer numbers, they train more family practice docs than any other school in the nation."

Boulger disputes the March 1995 *U.S. News & World Report* ranking UMD as the second most successful family medicine school in the United States. "We're No. 1," he says. "I have the figures in front of me. We've turned out a higher percentage of family physicians than any other school in the United States. I may be biased, but no one can touch UMD's record of producing family docs—rural or urban." A whopping 75 percent of UMD grads practice primary care. Forty-four percent of those practice in towns smaller than 20,000; the national average is about 9 percent.

How does UMD produce five times the national average of rural physicians despite the fact that students complete their last two years in the big city? Boulger's answer: "We select the right people. Train them properly. Then pray. Prayer is critical."

The University of Minnesota Duluth's formula for success is part selection, with generous helpings of style and substance. Selecting which 50 or so applicants will be admitted each year is part scientific, part intuitive, according to Lillian Repesh, Ph.D., assistant dean for Admissions and Student Affairs. "Exceptional MCAT scores and grade-point averages are minimum requirements," she says. "Beyond that, we look for personality traits that give them good potential for being a rural doc." Repesh says UMD evaluates each candidate for three things: family practice potential, rural potential, and people skills. "Most schools stop at academic potential," she says. "We place much more emphasis on people skills."

"We've found that students have to have lived about nine of their first 18 years in a small town before it becomes part of their souls," says Ron Franks, M.D., dean of UMD's School of Medicine. "This is a more powerful predictor than where they went to high school."

"That's not to say that if you're from Edina, you shouldn't apply," says Repesh. "We look for potential."



UMD's School of Medicine has a style all its own, just one part of its overall formula for success. Faculty cultivate a friendly, open-door rapport with physicians in the surrounding communities. "They know they won't get any guff from us," Boulger says. Many medical school faculties suffer academic tunnel vision, he says. They find it difficult to entrust their students to physicians practicing outside the walls of academe, fearing their students might learn bad habits. UMD's faculty are largely part-timers who practice medicine in area clinics. It was one of the first schools to essentially become a medical school without walls. Fall quarter has barely begun, and the 52 new students are out in community clinics learning alongside family physicians.

Small class size is part of UMD's style, but success goes beyond size. UMD alumni surveyed said the supportive family-like atmosphere and camaraderie fostered by medical school staff are what most influenced them to pursue rural practice. Thirteen of 20 faculty have been with the school since its inception in 1972. The entire staff has created a friendly, informal style immediately apparent to anyone who enters the administrative offices, where flannel shirts, khaki trousers, and beards—lots of beards—set the tone. "We learn names fast because names make you a person," says Boulger. "We have parties and dances—yes, we actually dance with each other. We have skit night where second-year students parody faculty. We are people first, faculty and students second."

UMD's style is an attitude. "Attitudes are hard to explain," says Boulger, "but if you saw pictures from our Halloween and Christmas parties, you'd understand. We teach and model balance in life [see profile of Byron

"We've turned out a higher percentage of family physicians than any other school in the United States. I may be biased, but no one can touch UMD's record of producing family docs—rural or urban."

—JIM BOULGER, PH.D.

'Re-engineering' the University's Academic Health Center

UMD School of Medicine Stays Two-Year

Plans to make the University of Minnesota-Duluth School of Medicine a four-year program have been put on hold, according to Ron Franks, M.D., dean of UMD's School of Medicine. The school's future will instead be folded into plans to reorganize the entire University of Minnesota Academic Health Center, which includes the schools of medicine, pharmacy, nursing, public health, dentistry, and veterinary medicine.

"Re-engineering," as it's called, started with a need to streamline the University Hospital in the face of declining funding and to sharpen the hospital's mission so it can maintain sufficient access to patients in today's integrated and managed care-dominated health care market. "We discovered that we can't change just part of the system," says Franks. "Everything, including tenure policies and every

clinical and administrative arm, will be on the table. We're asking: 'If we were CEOs building an academic health center from scratch, how would we go about it?'" Franks believes one outcome of re-engineering will be reduced barriers between campuses. "We won't be defending one school from another," he says. "Instead, we'll evaluate programs."

Re-engineering details will be announced in 1996. The University of Minnesota-Duluth School of Medicine will likely fair well, says Franks, because it already embodies many goals identified in the re-engineering plan: strong connections with local communities, a well-defined customer base (rural communities), and an external focus to meet the needs of constituents (rural communities and physicians).

Franks cites two areas of research likely to receive more attention as a result of the re-engineering plan: 1) health outcomes research: UMD will continue its work in quantifying the best way to treat heart disease and cancer in rural areas, and 2) medical economic development by building good relations with industry: UMD will provide research and other resources to biomedical firms interested in locating in rural Minnesota. "If biomedical firms can get the resources they need in a rural community, they will locate there," says Franks.

UMD medical students will continue to complete their third and fourth years in Minneapolis. However, Franks says the school is considering creating a rural practice experience for fourth-year students. It would be structured similarly to the Rural Physician Associate Program (RPAP), a nationally lauded elective program for third-year students at the university's Twin Cities campus in which students practice for nine months with a rural physician. Such a program would enhance the university's already well-known reputation for providing medical students with rural practice opportunities. —HB



Ron Franks, M.D., dean, UMD School of Medicine.

Crouse, page 6], and we work our buns off to make sure every student makes it. Clerical members of our staff have helped these kids simply by being there for them—to talk or get away for a Coke.”

Dean Franks summarizes: “At UMD, it’s impossible to fall through the cracks.”

Even families receive support and attention. “We know students don’t make it through medical school on their own,” says Boulger. “The spouse, children—they go through it, too, and our doors are always open to them.”

Substance

Preceptorships are at the heart of UMD’s success. On the first day with their preceptors, some first-year students accompany their docs to nursing homes. A few make house calls. Others spend a night on call, an exciting novelty, but not for long. “Some patients practically adopt the students,” Boulger says. “They tell them things they didn’t tell the doc.”

Students rave about the experience. “They come back grinning,” he says. “It really gives them a boost, which is why we space half-day visits throughout the first year.” First-year preceptorships are mostly observational until students develop adequate skills. Still, for the January final exam in the interviewing course, they submit a write-up of their first H & P’s. “It beats multiple choice,” Boulger says.

By the end of year one, students have listened to 30 or 40 normal hearts, so they’ve got a solid clinical base. They’ve gotten a peek at continuity of care and exposure to several patients with the same doctor. But the main purpose of first-year preceptorships is not to teach, but to pair students with a positive role model, one who will demonstrate that, yes, all this stuff we learn in class is necessary. “If they see the bugs and drugs they read about, it gives them an anchor that helps them retain classroom stuff much better,” says Boulger.

In year two, students immerse themselves in a physician’s life, literally moving in and living with the physician’s family for three days at a time, once in the fall, winter, and spring. “We tell them to superglue them-



Jim Boulger, Ph.D., director of UMD's preceptor program.

selves to the doc, except when they’re in the bathroom or bedroom,” says Boulger. “We tell them an added plus is the food is better than on campus.” If the doc has a noon Rotary luncheon, the student goes. If the doc goes duck hunting, so does the student. If the doc has a clinic management meeting, the student goes, too. If the doc paints his house on a day off, the student grabs a brush.

Students get matched with physicians as far away as Belcourt, North Dakota; Black River Falls, Wisconsin; but mostly in small Minnesota towns. “We get them away from urban medicine,” says Boulger, “and expose them to the excellent rural medicine practiced out there, and let me tell you, it is excellent.” Students learn early that rural docs are not isolated. They have access to specialists and use teleconferencing and computers to connect with an array of medical resources.

“I have well over 100 doctors who want students, and about 50 of them are mad at me because they didn’t get one,” says Boulger. “For the doctor, it’s fun—teaching at its best. You don’t have to prepare anything,

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.* Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every

week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

**To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)**

©1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by December 31, 1995. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

and you give the student clinical jewels they'll remember for a lifetime." Preceptors find it excellent continuing medical education because students constantly ask questions. The docs don't always have the answers, so they look them up with the students.

Making the right match between student and preceptor is crucial. Boulger is the medical school's Charles Kuralt, on the road, visiting and evaluating every clinic, physician, and family he matches with a student. If a student is interested in medical use of computers, he finds a preceptor who also is. He's had female students who wanted a female preceptor so they could see how the doctor balances work and family. And some students want a match near their home town. Once a match is made, he revisits to make sure things are going OK.

Many preceptors are former UMD students. "We look for physicians who were teachers of the year or Minnesota physicians of the year," Boulger says. "I try to make sure we have a low dork ratio among our preceptors."

The med school tries to accommodate the students' needs. "We had two students who were in love," Boulger says. "But they didn't think anybody knew it. They turned beet red when I asked if they'd like to be matched in the same town. I placed them with a husband and wife, both family physicians, who served as excellent models for how a two-doc family can succeed. The students eventually married and went into family medicine. In two or three years, I'll ask them to be preceptors."

Like year one, year-two preceptorships are intended not so much to teach clinical aspects of medicine as to provide a model for personal ethics and help the student form a professional style. "Another reason I like to visit the sites is to see the students smiling—and they always are," says Boulger.

Students who assist in their first delivery come back floating on air. One student experienced a moment of discovery while she helped Ray Christensen, M.D., in Moose Lake stitch up a 16-year-old who'd rolled his



Carol Farchmin, M.D., a family physician with Skyline Family Medical Center, P.A., in Duluth and a UMD preceptor, instructs first-year medical student Shara Johnson.

truck. She looked up from her work and uttered in a state of epiphany, "This is what I want—to take care of my friends and neighbors."

Another student set and cast a young man's broken arm. Soon after, he saw another young man with the same kind of fracture who'd first gone to the emergency department, then seen a radiologist and orthopedist. The cost difference for two people with the same problem was phenomenal. "The lesson learned is family medicine is cost-effective," says Boulger. "The reason rural docs handle 90 percent of what comes through the door is because they *can* handle it. There's a tremendous need for rural docs. The more we show students the pluses, the less likely they'll be swayed when they head for the Twin Cities."

Medicine is not all babies and broken arms. Boulger recalls walking in on a student and preceptor embraced

"99 to 1 Chance. I Took It"



Acutely ill, medically complex patients are our specialty. That's why Mr. Corey was transferred from an acute care hospital to the THC network of extended critical care hospitals. We're committed to a cost effective continuum of care for patients suffering from catastrophic illnesses or acute level chronic diseases. Aggressive therapies and outcomes-oriented programs return each patient to the most productive life possible. Just ask Mr. Corey. Given little chance of recovery, he wanted the most out of life. And he got it. A "99 to 1 chance. I took it and am getting well."



A Subsidiary of Translational Hospitals Corporation

6 1 2 - 5 8 8 - 2 7 5 0

*Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services*

and in tears over the death of a patient, the physician's friend. "It was the student's first encounter with a patient's death," says Boulger. "No one can teach that in the classroom. Medicine is a mean mistress. Students learn what they're getting into, including the pressures on family life."

Students learn how to handle everyday situations that occur when most patients are friends or neighbors. What do you do when Mrs. Winkelbean approaches you at the grocery store to talk about her bursitis? Boulger walked in on another student and preceptor discussing what to do about the child in the next room. The child had been repeatedly sexually abused. The parent who committed the abuse was in the exam room with the child as the student and preceptor spoke. What resources do we have in a town of 400 to deal with this? What needs to happen in the next five minutes? Police? What's the potential for violence? "Students learn that diseases are relatively easy to care for," says Boulger. "People are hard."

When students return to the classroom, they're fired up. "They don't complain about anything for a few weeks," says Boulger. "It works every time." Preceptorships in the first two years help students determine early on if rural medicine is right for them. Whether it is or isn't, the UMD program is good preparation for any specialty. **MM**

Howard Bell is a free-lance writer who recently moved from Duluth, Minnesota, to Onalaska, Wisconsin.

University of Minnesota Community Rotations Expose Students to Family Practice

As health care is shifting to outpatient and preventive medicine, so, too, is medical education.

Daniel P. Benzie, M.D., and Susan B. Frericks

In recent years, health care has shifted away from hospital-based medicine and focused more on outpatient and preventive medicine. As a result, academic health centers have recognized the need to shift their training focus from inpatient tertiary care centers to outpatient clinics and community hospitals. The University of Minnesota has responded by developing community rotations in the Duluth area for third- and fourth-year medical students. This initiative has been funded by MinnesotaCare legislation with the goal of training more primary care physicians in the state. The community rotation project was designed to increase the number of primary care physicians by training students in an environment supportive of primary care using the following approaches:

- involving subspecialty physicians who are willing to promote generalist disciplines;
- utilizing community settings where frequent contact with primary care physicians occurs;
- exposing students to the common problems seen in a specific discipline;
- allowing students to encounter patients early in the disease process; and
- helping students to develop a better understanding of health maintenance and prevention.

The community experience is intended to help students appreciate the diversity of health care providers involved in patient care and to observe the interrelationships between the patient, the family, and the community in health and disease.

The initial rotations were developed over the 1993-94 academic year, and 31 students took the rotations during the 1994-95 academic year. This report describes the development of the rotations, the student evaluations, the student and faculty feedback, and the changes that have been implemented for the next academic year. The authors hope other Minnesota communities will become involved in this program to enhance community medical education.

PROJECT DEVELOPMENT

The University of Minnesota Primary Care Task Force recommended in 1993 "embracing and nurturing relationships with community health care providers" by improving the medical school climate for students interested in primary care, increasing students' exposure to primary care role models, and increasing students' time in ambulatory settings. All such changes were considered during the development of the community rotations. The UMD School of Medicine and the University of Minnesota, Minneapolis campus, worked together and followed the MinnesotaCare legislative request to establish the community rotations in Duluth. The Duluth area was selected as a site and hub for these community clerkships because of its long history of excellence in medical education, the presence of a strong and nationally recognized family practice residency program, its community of patients and medical staff who support the concept of education in a community environment, and the presence of the University of Minnesota-Duluth School of Medicine. The UMD School of Medicine is a two-year school that has received national recognition for its excellence in preparing students for rural family practice (see related cover story, page 10).

Course directors and department heads at the University of Minnesota-Minneapolis first reviewed the course goals and objectives. Next, community faculty for the rotations were chosen based on their interest and history of medical education. We (the authors) met with the community faculty individually to answer questions, review concepts of office-based teaching, and clarify the goals and objectives of the various rotations. We presented general information about the community rotations to the family practice residents and residency faculty, the medical staffs at the local hospitals, other community health care providers, and hospital and clinic support personnel. Arrangements for free housing were made for students on the rotations, as well as for free meals while they were on duty.

FACULTY TRAINING

We held a seminar, "Introduction to Teaching in the Office Setting," for first-time community faculty and office personnel with no previous experience with medical students. Under this teaching model, the community faculty make an initial assessment of the student's level of training, previous experiences, and current skill level, and the student and community faculty then agree on the content to be taught. The model incorporates a variety of specific teaching methods that can be used in the office setting. It reinforces frequent and positive feedback and encourages students to meet the following primary care teaching goals:

- observe the full spectrum of diseases within the discipline;
- develop an understanding of the problems common to the discipline;
- understand the concepts of prevention and wellness;
- refine patient communication skills;
- integrate clinical problem solving; and
- identify faculty role models.

DIDACTICS

Medical students doing rotations in academic health centers receive instruction from the faculty and residents. Alternative methods must be applied in the community sites. The students in Duluth community rotations participated in lectures at the beginning of surgical subspecialty rotations. They participated in problem-based learning (PBL)* cases on the ob/gyn rotation, viewed videotapes of midweek lectures on the ambulatory medicine rotation, and participated in a number of hospital conferences.

EVALUATIONS

One key to establishing any new medical training initiative is determining how to evaluate the program to assure it is meeting the outlined goals. We developed a number of new evaluation tools and also used the university's standard examination and evaluation methods to assess student knowledge, skill development, and attitudes.

Students in the program were required to maintain a logbook of all patient encounters, recording patient age, diagnoses, location of the encounter (office, hospital, surgical suite, or emergency department), and the student's level of involvement (observed, assisted, or performed) for any examinations done. In addition, faculty from the Department of Family Medicine, University of Minnesota-Duluth School of Medicine, held weekly meetings with the students to review patient encounters, address any administrative problems, and facilitate case presentations. During the last week of the rotation, the students completed an extensive written evaluation,

followed by a one-hour oral evaluation given by the authors of this report to determine whether the community rotations were meeting student, clerkship, and Minnesota-Care goals.

THE STUDENTS

A total of 31 third- and fourth-year medical students, most of whom grew up in Minnesota (88%) participated in rotations. These students spent their first two years of medical training at the UMD School of Medicine (26) or the University of Minnesota in Minneapolis (5). Table 1 outlines the rotations taken. The students' average age was 26.8 years; 58% were men, and 54% were married.

PATIENT ENCOUNTERS

The students saw, on average, 67 patients per week, ranging from a low of 35 to a high of 121. The students encountered patients in a variety of clinical settings, including outpatient clinics, emergency departments, hospitals, and in surgery. Twenty-five percent saw patients in rural outreach clinics. Other students participated in Duluth's Community Health Clinic, a sports therapy center, various rehabilitation sites, and local high school and college sports medicine clinics. These settings provided students the opportunity to work with other health care providers, to work with the patients' primary care physicians, and to develop an appreciation for the role physicians play in the community.

Table 2 shows the average percent of time students spent in each location as reported in the patient logbooks or by student estimates when logbook data were not available. On average, students spent 65% of their time in the clinic, 2% in the emergency department, 15% on the hospital wards, and 18% in surgery. The exceptions were students in emergency medicine (all encounters in the emergency department) and radiology (all encounters in the hospital setting).

Ambulatory rotations expose students to a diversity of common medical problems. The logbooks show the students encountered a large number of problems and procedures, including the most common medical and

Table 1

Rotations taken

Rotation	# of students
Ambulatory medicine	1
Emergency medicine	2
ENT	6
Family practice	2
Neurosurgery	1
Ob/gyn	7
Orthopedics	2
Radiology	6
Sports medicine	1
Urology	3
Total	31

*An initial case is given to the students early in the week; they work on solving the case independently and review it later in the week with community faculty.

Table 2

Average percent time spent in each setting

	Clinic	Emergency department	Hospital	Surgery
ENT	55%	—	2%	43%
Family practice	65%	5%	30%	—
Ob/gyn	55%	—	28%	17%
Orthopedics	60%	10%	2%	28%
Neurosurgery	56%	1%	30%	13%
Sports medicine	70%	—	10%	20%
Urology	96%	<1%	<1%	3%
Overall percent	65%	2%	15%	18%

surgical problems within each discipline.

The students' level of involvement, as identified by their written and oral evaluations, indicates that overall they performed the patient examination 26% of the time, assisted 25% of the time, and observed 49% of the time. Because this is a new program and the private offices are still adjusting to students, the level of involvement is not as high as might be anticipated in a full-time teaching facility. However, the students generally felt they received an appropriate amount of experience.

STUDENT FEEDBACK

As mentioned above, students completed an extensive written evaluation at the end of each rotation, followed by a one-hour oral evaluation with a faculty member and an evaluation specialist. The students have used both the written and oral evaluations to critique the community rotations and to offer suggestions for improvements. Generally, students were satisfied with their one-on-one contact with physicians and the "excellent teaching." Students commented that the rotations provided good exposure to the ambulatory setting, as well as to surgery, on a daily basis. They also commented that the rotations provided outreach opportunities in rural settings, which helped the students understand the roles of family physicians in treatment, management, and referral. As for improvements to the program, the students said they would like to have more hands-on experience and more initial patient contact. They also suggested that the program should educate hospital and support staff on the level of patient care the students are capable of providing.

We also asked the students to evaluate their level of

confidence in responding to different types of patient problems or performing procedures encountered during their rotations. These results show the students developed confidence not only when they performed the examination, but also when they assisted or observed various procedures and patient problems. Overall, the students seemed to develop confidence in the assessment and management of common problems encountered in each of the disciplines.

FACULTY FEEDBACK

In the offices that were teaching medical students for the first time, several issues needed to be addressed. These included determining who would obtain patient permission; when the student would be in the office, the hospital, or in surgery; and what the student's daily schedule and call responsibilities would be.

Some faculty were concerned about maintaining an efficient patient flow, giving the students enough instruction, and providing enough "hands-on" experience. Subsequently, the faculty have asked for more reference materials and didactic suggestions.

The office staff and faculty all agree that the students add enthusiasm to the office and that patient acceptance is very high. We continue to receive feedback from the faculty and office staff, and all offices have requested more students.

DISCUSSION

Ambulatory training can be very successful, as has been demonstrated by the Yankton model program¹ and reviewed by Lesky and Hershman.² As medicine moves to the outpatient setting, our education needs to follow to expose students to the patient problems they will encounter in their future practices.

It appears that the Duluth community rotations are meeting the established goals. The students have been exposed to community practitioners and have witnessed the interaction between subspecialty and generalist physicians, dealt with common medical problems and procedures, and learned to work with other health care providers in caring for a community of patients.

Based on student and faculty feedback, we have made a number of improvements to the community clerkships:

1) We have incorporated more didactics, primarily in the form of problem-based learning cases. The instruction will cover more basic sciences and will include a review of physical diagnosis skills and an expanded review of problem-solving skills. We will begin offering departmental lectures on a telecommunication system when appropriate.

2) We have added more student visits to rural outreach clinics to increase exposure to primary care.

3) We have revised the patient logbook, which we will begin to computerize. In the future, we plan to issue students pocket-size computers for tracking their clinical experiences.

We encourage the University of Minnesota to continue to explore new curricular alternatives and to expand

ASPEN Medical Group

Ob/Gyn

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 14 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

its programs to other communities throughout Minnesota. Our community physicians, clinics, hospitals, and, most important, our patients, are excellent and supportive resources for the future of medical education. **MM**

Daniel Benzie is director of the junior and senior clerkships at the University of Minnesota-Duluth School of Medicine and a family physician in Moose Lake, Minnesota. Susan Frericks is an evaluation specialist at the University of Minnesota-Duluth School of Medicine.

REFERENCES

1. Hansen LA, Talley RT. South Dakota's third-year program of integrated clerkships in ambulatory-care settings. *Acad Med* 1992;67:817-9.
2. Lesky LG, Hershman WY. Practical approaches to a major educational challenge: training students in the ambulatory setting. *Arch Intern Med* 1995;155:897-904.

EXERCISE

Does Your Heart Good.



American Heart Association

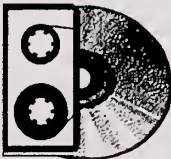
CUT OUT TRANSCRIPTION EXPENSE NOW

Dictation Plus is the most advanced and only Microcassette/Computer based voice recognition system available.

- Totally Automated - No more need for transcription services
- Chart notes the same day
- No change in practitioners dictation habits
- No new tasks to learn
- Dictate as long as needed
- Save up to \$50,000 per year

Total Practice Hardware, Software, Training
Under \$10,000

For a free brochure or more information,
Call: (612)535-2872 today, and thank us later!

igital
ictation
Systems, Inc.

Digital Dictation Systems, Inc.
4600 Lake Road
Robbinsdale, Minnesota 55422

Remember: It's not just the money saved.

Retirement of Senior Physicians in Rural Minnesota

Factors Influencing Physicians' Plans to Retire

Julia Lee, B.S., Thomas Lenzmeier, B.S.E., James Boulger, Ph.D.,
Sally Buck, M.S., Dale Bergeron, M.A., and Terence J. Hill, M.P.A.

ABSTRACT

The demand for physicians in rural Minnesota is likely to increase significantly over the next few years. Nearly 20% of all rural physicians in Minnesota are older than age 65. This paper reports the results of a survey of rural Minnesota physicians over age 60 on their current practices and their plans for retirement. Of the 33 physicians questioned, 25 (75%) currently had plans to retire and more than half of the 25 planned to retire in the next two years. Factors that these physicians perceived as important in determining their decisions to retire or continue practice are described, and implications for the delivery of health care in rural communities are discussed.

Nationally, one in 14 of all Americans live in areas with health care provider shortages.¹ Without an adequate supply of primary care providers, patients in these communities may not receive needed health care or may have to delay treatment and travel to other areas to receive care. A shortage of primary care physicians in rural Minnesota is one cause of health care access problems for many state residents. More than 263,000 people in Minnesota (18% of the non-metro population) live in areas designated as rural primary care Health Professional Shortage Areas.² To be designated a primary care Health Professional Shortage Area, an area must have fewer than 28.6 primary care physicians per 100,000 population, or 3,500 people per physician.²

The demand for physicians in rural Minnesota is likely to increase significantly over the next few years. More than 10% of primary care physicians in non-metro areas are over age 65, as compared with 4.9% in metro areas.²

Vacancies created by retiring physicians are difficult to fill with just one newly trained physician because of differences in efficiency and quality-of-life choices. Many newly trained physicians see only about two-thirds the number of patients seen by seasoned physicians.³ With their disproportionately large number of older health care providers, rural areas could be adversely affected when experienced, competent physicians retire in the near future.

For many rural communities, recruiting a physician has become a long and difficult task. Currently, there is a demand in rural Minnesota for approximately 170 family physicians, according to an annual study by the Minnesota Center for Rural

Health conducted under contract with the Minnesota Department of Health, Office of Rural Health.⁴ Nearly 70% of all rural hospitals are actively recruiting physicians. This recent study indicates that the demand for physicians has grown since the Minnesota Hospital Association and the Minnesota Medical Association conducted recruiting studies in 1989 and 1991.² To successfully place just one physician, hospitals and clinics statewide must recruit for an average of 12 months. In areas that have hospitals with less than 25 beds, the average recruitment time is longer than two years.²

The purpose of this study is to examine the factors influencing the retirement of rural family physicians in Minnesota and to determine the amount of planning physicians undertake before retiring. Determining senior physicians' current levels of practice, plans for retirement, and anticipated involvement in health care after retirement will help rural communities and policymakers make plans for providing access to primary health care in the future.

METHODOLOGY

We obtained a list of all Minnesota family physicians over age 60 from the Minnesota Academy of Family Physicians (MAFP). We identified a total of 61 MAFP members over age 60 practicing outside the seven-county metro area (Anoka, Carver, Ramsey, Hennepin, Dakota, Scott, and Washington counties) and outside the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud. This represented 44.5% of the total MAFP membership over age 60. Of the 61 names on the list, we deleted six; one physician was an obstetrician/gynecologist, and five had incomplete addresses or phone numbers. The

resulting population was 55 physicians.

We developed a 10-minute telephone survey that two second-year medical students from the University of Minnesota-Duluth conducted. Practicing rural physicians and other professionals involved in rural health care reviewed the survey. All rural family physicians over age 60 ($n=55$) were eligible for participation, and we mailed a sample list of questions and a cover letter explaining the study to 70% of this group ($n=39$) to solicit at least one participant from each rural Minnesota county. The two medical students called all 55 physicians to schedule a 10-minute telephone interview. Twenty-nine physicians completed telephone interviews. Four additional physicians completed the sample survey they received in the mail and returned written answers (not on request), giving a total of 33 respondents. The written surveys did not appear to be different from the telephone responses. The 33 respondents represented practices in 29 non-metro Minnesota counties. The other physicians had either retired ($n=4$), were out of town ($n=1$), or did not respond to repeated phone calls ($n=17$).

The survey consisted of 24 questions. The majority required a "yes" or "no" response or a numerical rating. A few open-ended questions were included to develop a general picture of the physician's practice. On a scale of zero to 10 (no influence to major influence), physicians were asked to rate 14 factors, both personal and professional, that might influence when they would retire. Physicians were given the opportunity to comment on high ratings.

The survey was designed to collect information in two steps. The first questions assessed the physicians' current level of practice. The next questions asked about the physicians' future retirement plans and the factors that might influence their decision to retire. Responses were recorded during the interview, coded by category, and analyzed using the Statview® computer program.

RESULTS

The mean age of the 33 physicians surveyed was 65, with a range from 61 to 72 (see Table 1). Most physicians surveyed had spent the majority of their careers in the same community. The average length of their professional careers was 37.7 years,

with an average of 29.8 years in their present communities. The respondents included 32 male physicians and one female physician.

The physicians' weekly work schedules varied greatly (range=18 to 90 hours). Their average workload was 45 hours per week with an average 23 patient visits a day. Seventy-three percent said they took call every fourth night or less frequently, and 27% said they took no call at all. Sixty-six percent of responding physicians took weekend call less than one weekend a month; however, 12% had call every weekend. The range of vacation time was from zero to 19 weeks per year, with an average of four weeks.

Thirteen respondents were in solo practice, and another 13 were in family practice groups. Six physicians practiced in multispecialty clinics, and one practiced at a state hospital (see Table 2).

The physicians estimated the number of geriatric, pediatric, obstetric, and other adult patients they typically saw. A large number of their patients were over age 65 (mean=50%). Pediatrics and obstetrics patients made up smaller mean percentages at 13% and 1.5%, respectively, or 35% of the patient visits. On average, 67% of the physicians' patients were covered by Medicare or Medicaid, and 23% had private insurance.

Of the 33 physicians questioned, 25 (75%) currently had plans to retire. The remaining eight were not sure when they would retire or had not made plans to retire. Over half

Table 1

Senior physician population in rural Minnesota

Category	Mean	Std. dev.	Range
Age	65.1	3.14	61-72
Years practiced in present community	29.8	11.6	1-45
Total years in practice	37.7	4.1	27-46
Hours worked per week	45.0	16.3	18-90
Patients seen per day	23.1	7.5	11-40
Vacation time (weeks)	4.1	4.2	0-19
Predicted retirement age*	67.3	2.9	62-73
Years until predicted retirement†	2.8	2.3	0.1-10

* $n = 26$

† $n = 25$

Table 2

Type of practice

Category	Frequency	Count
Solo	39.4 %	13
Family practice group	39.4%	13
Multispecialty group	18.2%	6
Other	3.0%	1

Table 3

Predicted retirement age of rural family physicians

Age	Frequency	Count
61	0.0%	0
62	4.0%	1
63	12.0%	3
64	0.0%	0
65	16.0%	4
66	8.0%	2
67	8.0%	2
68	16.0%	4
69	8.0%	2
70	12.0%	3
71	12.0%	3
72	0.0%	0
73	4.0%	1

*n = 25

Table 4

Degree to which factors influence physicians' decision to retire

Influencing factor	Rank	Mean	Std. dev	Median
Health care reform	1	6.8	3.3	8
Cost of practicing	2	5.2	3.7	5
Malpractice	3	5.1	3.9	5
Personal time	4	4.7	3.3	5
Call schedule	5	4.0	3.7	4
Personal health	6	4.0	4.2	2
Family influence	7	3.8	3.6	5
Financial situation	8	3.6	3.7	2
Workload	9	3.3	3.2	2
Finding a replacement	10	3.3	3.2	0
Community support	11	2.2	3.0	0
Closure of medical facilities	12	1.8	3.5	0
Continuing education	13	1.8	2.0	2
Partners (if applicable)	14	1.5	3.3	0

the 25 physicians planned to retire within the next two years, with a range from one month to 10 years until planned retirement (see Table 1). Table 3 shows the predicted retirement age of the 25 physicians planning to retire. Thirty-one percent of those planning to retire had not conveyed their plans to their communities. More than 60% of all surveyed physicians planned to stay involved in health care following retirement. Although the majority were unsure how they would remain involved, working as locum tenens (n=5) was indicated most frequently, followed by performing voluntary medical services (n=4).

Physicians in solo practices predicted that after they retired, their patients would receive care from several sources. Thirty-one percent ex-

pected their patients would go to another clinic in the same town, and 38.5% said their patients would need to find a doctor in a neighboring town. Fifteen percent of the solo physicians said they intended to recruit someone to take over their practice before they retired. Another 15.4% did not know where their patients would find care. All respondents in group practices said their patients would be referred to their partners. Twenty of the 33 respondents reported that they were currently recruiting new physicians to fill a vacancy or to prepare for expected retirements.

Table 4 shows the reported influence of 14 different factors on the respondents' decisions to retire. Health care reform was the most influential factor for these older

physicians (mean=6.8). The cost of practicing was the second most highly rated factor (mean=5.2), followed by concern over malpractice (mean=5.1). A desire for personal time (mean=4.7), concern over personal health (mean=4.0), and family influences (mean=3.6) also rated in the top half of possible reasons for retiring.

Seventy-five percent of respondents said they felt adequately informed about changes in the health care system. The majority said they obtain their information from journals and meetings.

Finally, 20 physicians (61%) identified issues and obstacles over the next five years that might affect their decision to continue their medical practice. These included government regulations (n=6), health care reform

(n=4), bad health (n=2), cost of practicing (n=2), malpractice (n=2), paperwork (n=2), insurance (n=1), and the Clinical Laboratory Improvement Act (n=1).

DISCUSSION

FACTORS LEADING TO RETIREMENT

Senior physicians we surveyed ranked health care reform as the most influential factor leading to retirement. Many physicians expressed fear of "socialized medicine" and "cook-book medicine" and said they felt they were becoming scapegoats for the nation's health care problems. One physician said, "The social value of a physician is the lowest it has ever been." Physicians who rated health care reform as a 10 (of major influence) tended to be older, see more elderly patients, and use less vacation time. Most of the physicians surveyed felt adequately informed about changes and reforms in the health care system; however, they often felt helpless and excluded from the reform process.

The cost of practicing was the second-highest-ranked factor influencing physicians' retirement. The 1991 Family Physician Cost and Production Survey found that average clinic overhead expenditures as a percentage of actual revenues in Minnesota that year was 56.1%. The overhead percentage for family physicians in practices with three or fewer physicians was reportedly 60%.⁵ With 39% of our survey respondents in solo practice, the cost of practicing understandably received a high rating.

Respondents also identified lower Medicare payments as influential in the decision to retire. About half the respondents' patients use Medicare benefits.

TRENDS

One striking trend was the large percentage of geriatric patients the physicians saw. On average, 50% of respondents' patients were elderly. Because the physicians surveyed have practiced in the same communities an average of 30 years, they have treated many of the same people throughout their careers.

Physicians who had remained in their communities the longest were typically solo practitioners (39% of the physicians surveyed). Only 7.8% of Minnesota's family physicians are in solo practice,⁵ so the number of senior physicians in solo practice is disproportionately large. Changing practice styles and increasing overhead costs have spurred the formation of group practices, while the number of solo practitioners has dwindled. A national survey of 1992 medical residents found that only 10% to 15% of family practice residents preferred solo practice.⁷

CONTINUITY OF CARE

Of the solo practitioners planning to retire in the next five years, only 55% had informed the community of their retirement plans. Forty-six percent of the solo physicians either did not know where their patients would receive care after they retired or said that patients would probably have to go to another town to receive care. In contrast, all physicians in group practices said their patients would receive care from their partners, but this assumption may be faulty if the group must recruit additional providers to handle increased patient loads.

Only about one-third of the solo physicians are attempting to recruit new physicians; few harbored any hope of selling their solo practices, and many felt they would have a hard time giving their practices away. Some physicians felt the 2 percent provider tax on physicians' gross incomes and the \$400 licensing surcharge are major barriers to recruiting practitioners from other states.

Many respondents hoped to remain involved in health care after retirement, yet many expressed concerns about the cost of continuing such activities. Minnesota partially recognized this concern when it passed legislation to exempt retired physicians from the \$400 license surcharge recently added to licensing fees.⁶ Malpractice insurance is another concern for retired physicians. Typically, physicians who practice part time are required to pay the same malpractice insurance premiums as full-time physicians.

PUBLIC INITIATIVES

Direct assistance initiatives for senior physicians could be developed, such as financial support through tax incentives or special malpractice rates to encourage physicians to practice part time after retirement. Before retirement, personnel support through locum tenens and mid-level practitioners could help alleviate frequent call schedules, long work hours, and premature burnout.

Rural communities with physicians over age 60 should be discussing plans for maintaining continuity of care. To ensure continued access to needed services, rural citizens must assume responsibility for their local health care systems and must work with health care providers to identify and address existing problems. Rural leaders can help physicians assess community health needs, educate local citizens, develop rural health networks, and support future health care provider recruitment and retention efforts.

MM

A copy of the survey instrument used in this study is available upon request from the Minnesota Center for Rural Health, 600 East Superior Street, Suite 404, Duluth, MN 55802; 218/727-9390.

ACKNOWLEDGMENT

This study was supported by the Minnesota Department of Health, Office of Rural Health and Primary Care, through the federal Office of Rural Health Policy.

Julia Lee and Thomas Lenzmeier are fourth-year medical students at the University of Minnesota Medical School. James Boulger is director of the family practice preceptor program and associate professor in the Family Medicine and Behavioral Sciences departments at the UMD School of Medicine. Sally Buck is program manager of placement and retention at the Minnesota Center for Rural Health. Dale Bergeron is a program director at the Minnesota Center for Rural Health. Terence Hill is executive director of the Minnesota Center for Rural Health and a member of the State Rural Health Advisory Committee.

REFERENCES

1. Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services. Rural health profession facts: family and general practice physicians: supply and distribution. Chapel Hill, North Carolina: University of North Carolina, 1988:1-4.
2. Minnesota Department of Health, Health Systems Development Division, Health Economics Program. Providing medical care in rural Minnesota: recommendations for meeting health personnel needs. Minneapolis: Minnesota Department of Health, 1991:39-62.
3. Bergeron D. Rural health care provider crisis: a cooperative approach to a multifaceted problem. Duluth, Minnesota:

Minnesota Center for Rural Health, 1993: 2-3.

4. Minnesota Center for Rural Health. Physician and mid-level practitioner demand assessment. Duluth, Minnesota: Minnesota Center for Rural Health, 1995:7-10.

5. Minnesota Academy of Family Physicians. A study of family physician cost and

production in Minnesota for 1991 year. Minneapolis: Minnesota Academy of Family Physicians, 1993:10-11.

6. Christensen R, ed. 1993 legislative summary. Minnesota Family Physician, Summer 1993:5.

7. Solo is no go for graduating residents. Unique Opportunities 1992;2(4):30.

HealthEast Capitol Medical Laboratory Service • Quality • Commitment

HealthEast Capitol Medical Laboratory is **locally** owned and operated

CML responds quickly to client needs on a 24-hour-per-day, 7-day-per-week basis

Our CME programs are approved by the ASCLS and AAMA. Nursing documentation also provided

Medicare Part A billing provided

We offer flexible corporate health and wellness programs

For more information, contact CML Marketing at (612)

232-3246

HealthEast  Capitol
Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102
Customer Service: (612) 232-3500



THIS PUBLICATION AVAILABLE FROM UMI

UMI

A Bell & Howell Company
Box 78, 300 North Zeeb Road
Ann Arbor, MI 48106
800-521-0600 toll-free
313-761-1203 fax

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed

and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use JAMA style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986:522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Life After Medical Practice

A Retirement Profile of Minnesota Physicians

Harold C. Seim, M.D., M.P.H., and James E. Mitchell, M.D.

ABSTRACT

This study investigates the current dynamics of physician retirement in Minnesota. A survey of all retired Minnesota physicians (878, with 65.7% response rate) revealed that 73% retired in their 60s, 22% at age 65. Good health was reported by 69% of the respondents, and fair health by 26%. Income was sufficient in most cases; 64% of respondents reported living comfortably, and only 14% said their incomes are barely adequate. The study also showed that retired physicians consider nonmedical activities much more important than medical activities; heading the list were visiting family (86%), reading (79%), and travel (63%). Finally, 35% of respondents found retirement to be better than they had expected, 54% found it about as expected, and only 9% felt retirement was not as good as expected. In retirement, Minnesota physicians are generally healthy, have sufficient funds to live comfortably, and generally spend their time doing nonmedical activities.

Thirty or 40 years ago, physicians typically worked until they died or until declining health forced them to retire. Since the late 1970s, there has been a growing trend among physicians to choose retirement. Studies relate retirement to such reasons as increasing costs of malpractice insurance and physician frustration with administrative tasks.^{1,2} On a more positive note, Alberts argues that many physicians want an "opportunity to embark on activities sublimated during the working years," suggesting that the desire to develop and explore personal recreational activities also plays an important role.³

Once physicians decide to retire, they face significant lifestyle changes. The manner in which retirees approach this new lifestyle affects their satisfaction. Gaitz advises physicians to plan for retirement during the peak of their careers to avoid being overwhelmed by planning later.⁴ According to Virshup et al., the lifestyle changes retirees experience may be associated with decreased self-esteem and psychological disturbances.⁵ Brooke emphasizes a need to seek out ways to combat the loneliness that may follow the loss of working interactions and recommends that individuals begin before they retire to develop new interests and hobbies that will replace current activities.⁶ Dunkel asserts that "satisfaction in retirement depends less on how active you are than on the ability to develop a lifestyle that provides continuity with your past and meets your long-term needs."⁷ She stresses the importance of extensive financial planning to achieve financial security in retirement.

The study reported here was undertaken to explore Minnesota physicians' reasons for retirement, their

activities and interests, their financial situations, and their personal satisfaction with retired life.

METHODS

A questionnaire was developed and pilot tested with three retired physicians. After formatting it into a computer-readable document, the questionnaire was mailed to all retired physicians in Minnesota.

RESULTS

A total of 878 questionnaires were mailed, and 577 were returned (65.7%). Male respondents accounted for 92.2%, female 3.5%, and 4.3% did not specify their gender. Seventy-three percent of respondents retired in their 60s, with 22% retiring at age 65.

The three specialty areas heading the list of respondents were family medicine, represented by 23%; internal medicine, at 12%; and surgery, at 6.1%. Table 1 lists all specialty areas represented and the numbers and percentages of respondents within each discipline.

Geographical distribution results revealed that 51% of the respondents had practiced in the Twin Cities metropolitan area, 33% in small cities or towns, and 12% in rural communities, with 4% not specifying. Since retirement, 65% remained in their homes, 18% had moved to condominiums, and 11% had moved to retirement communities. Of those who had moved, 44% had moved to a different area of the country, 18% had moved to the community in which the physician or the spouse had been raised, and 15% had moved to a smaller community. Forty-nine percent of the respondents reported spending time in the southern states during the winter. The most popular desti-

Table 1

Retired Minnesota physicians' reported specialties

Specialty area	Number	Percent
Family medicine	132	23.0%
Internal medicine	69	12.0%
Surgery	35	6.1%
Radiology	32	5.5%
Obstetrics	32	5.5%
Pediatrics	27	4.7%
Pathology	22	3.8%
Psychology/neurology	21	3.6%
Colon/rectal surgery	18	3.1%
Ophthalmology	15	2.6%
Orthopedics	14	2.4%
Other	73	12.6%
No information	87	15.1%
TOTAL	577	100.0%

nations for those who travel to warmer climates include Florida (22%), Arizona (16%), Texas (4%), and California (4%). Fifteen percent of the respondents stay for one month, 10% stay two months, and 3.5% to 7% stay three to six months. However, only 10% of the respondents own a home in the Sun Belt.

The median number of years spent in medical practice was 36, with a range of three to 65 years. Most physicians had been in one or two practices (31% and 32%, respective-

Table 2

Total net worth of Minnesota physicians at retirement

Total net worth	Percent
<\$250,000	10%
\$250,000 to \$500,000	26%
\$500,000 to \$1 million	37%
\$1 million to \$2 million	20%
\$2 million to \$3 million	5%

ly), 13% had been in three practices, and 10.4% had not been involved in clinical practice. The longest time in one practice was a mean of 31 years, with 30% of the physicians in the 21- to 30-year range, and 42% in the 31- to 40-year range.

Sixty-nine percent of the respondents reported good health, and 26% reported fair health. Only 19.5% of respondents reported that their activities before retirement were limited by either their own health status or their spouses' health status, whereas after retirement, 33% said health-related problems limited their activities. Fifty-six percent said they had been hospitalized since retirement, and 53% had undergone surgery.

The average annual gross income before retirement was \$50,000 to \$100,000 for 43% and \$100,000 to \$200,000 for 31%. Only 1.2% reported an income above \$300,000. The average net worth of physicians at retirement was between \$500,000 and \$1 million. The net worth distribution is detailed in Table 2. Before retiring, 41% of the respondents were uncertain whether they had enough money to retire, and only 35% indicated that they had been involved in any financial planning. As for annual income in retirement, 30% reported less than \$50,000, 33% reported \$50,000 to \$75,000, 24% had \$75,000 to \$100,000, and 13% had

incomes over \$100,000 per year (see Table 3). Sixty-four percent of the retirees live comfortably on their incomes, while 14% said their incomes are barely adequate. Nonetheless, 59% reported that they save money in retirement.

No single theme emerged in the list of reasons for choosing retirement, although the two categories rated "very important" and "moderately important" most frequently were aggravation with third-party medicine (34%) and a desire to undertake other activities (33%). About one-fourth of the respondents cited the high rates of malpractice insurance as very important or moderately important, and similar ratings went to attaining mandatory retirement age (24%) and diminished satisfaction with work (24%). These and other factors are shown in Table 4.

Involvement in medical activities during retirement was apparently not as important as participation in nonmedical activities. The medical activities rated very important or moderately important were reading medical literature (41%) and attending medical meetings (32%). Other medical activities included volunteer work (17%), consultation (13%), and writing on medical topics (6%). Nonmedical activities rated as very or moderately important were visiting family (86%), reading nonmedical literature (79%), travel (63%), music (56%), gardening and yard work (51%), participation in sports (39%), watching TV (34%), nonmedical volunteer work (30%), crafts (26%), photography (26%), arts (24%), and other (24%).

Finally, 35% of the respondents said retirement was better than they expected, 54% said it was about what they expected, and about 9% said it was not as good as expected.

DISCUSSION

Shorter life spans at the turn of the century meant the average male worker could expect to spend just 3% of his life in retirement. Now a person can expect to spend 20% to 25% of life in retirement.⁸ The average life expectancy for a 65-year-old man in

1990 was 80.1 years and for a woman was 83.9 years, allowing an average time in retirement of 15.1 years for men and 18.9 years for women.⁹ Planning for retirement assumes more importance as it involves a larger portion of a person's life.

In the past, physicians frequently didn't retire. Physicians enjoyed a greater degree of prestige than they do today, which kept them in the workforce. Also, retirement programs were not common, and many physicians could not afford to retire. Some people felt that retirement had a deleterious effect on health because almost everyone knows someone who retired and died shortly afterward. Studies, however, have not supported this belief.^{3,4,10}

The results of the study reported here reveal many positive aspects of physician retirement. Good health, sufficient money, and increased time for family interaction are the recurring themes emerging from this survey, all of which are noted in the literature as important features for successful retirement.

An analysis of net worth shows that family practice and internal medicine physicians each comprised 14.9% of the net worth categories of greater than \$1 million. However, neither of these specialties represents a large portion (4% and 9%, respectively) of the physicians earning more than \$200,000 per year. In contrast, 100% of the responding surgeons reported earning over \$200,000 and also represented 14% of the physicians whose net worth was greater than \$1 million. This supports the old adage, "It isn't what you make but what you save that is important in the end."

Our results showed nonmedical activities to be much more important during retirement than medical activities, revealing a significant shift in priorities once physicians leave their medical environments.

Gaitz describes four patterns of retirement with which retirees identify. The first pattern, maintenance, "satisfies needs in essentially the same way after retirement as before." The retiree keeps working, with the goal of keeping everything as it once was. The second pattern, withdrawal, is

Table 3

Annual income of Minnesota physicians during retirement

Annual income	Percent
<\$50,000	30%
\$50,000 to \$75,000	33%
\$75,000 to \$100,000	24%
\$100,000 to \$150,000	10%
Over \$150,000	3%

chosen by people who "view retirement as a time to relax, to give up some former activities and interests, but also to adopt some new ones." Third is the transfer-of-needs pattern, in which "a person attempts to satisfy the same kinds of needs as before retirement by engaging in different kinds of activities." In the fourth pattern, retirees develop new functional needs. Gaitz says this is "useful for persons who view retirement as a relief from external pressures, with freedom to do wished-for activities that have been postponed."⁴ Results of the survey described here show that physicians tend to fall in the "new-functional-needs pattern"—they are hoping to enjoy activities that they previously did not have time to pursue.

Dunkel asserts that physicians should consider the importance of such things as "achievement, prestige, helping others, and intellectual stimulation."⁷ By doing so, physicians can pursue those activities that will help to increase satisfaction with their new retired lifestyle. Veninga says, "Those who have an agenda, in terms of starting a new career, using skills in a volunteer capacity, or developing a meaningful avocation, tend to have excellent retirements."¹¹

CONCLUSION

In retirement, Minnesota physicians are generally in good health, have sufficient funds to live comfortably,

Table 4

Reasons for retirement:

Retired Minnesota physicians who rated the following reasons as "very important" or "moderately important"

Reasons	#	%
Aggravation with third-party medicine	197	34%
Desire to undertake other activities	192	33%
Reached mandatory retirement age	144	25%
Diminished satisfaction with work	139	24%
High cost of malpractice insurance	139	24%
Fear of loss of competence	110	19%
Impaired health	105	18%
High office overhead related to paperwork	86	15%
Change of career	44	8%

and spend most of their time pursuing nonmedical activities. **MM**

Harold Seim is an assistant professor with the Department of Family Practice and Community Health at the University of Minnesota Medical School, and James Mitchell is a professor with the Department of Psychiatry, University of Minnesota Medical School.

REFERENCES

1. Beasley JW. Wisconsin's family physician shortage. *Wis Med J* 1989;1:11-4.
2. Butler RN. Physicians not exempt from "forced retirement." *Geriatrics* 1989;44(1):19.
3. Alberts ME. Time to plant the roses. *Iowa Med* 1988;78(12):567-8.

continued

EXPERTISE



Norwest Private Banking:

Expertise for the
Medical Profession.
Unexpected Services,
Uncommon Privileges.



To The Nth Degree™

Minneapolis 667-0705
©1995 Norwest Bank Minnesota N.A.
Member FDIC

4. Gaitz CM. Planning for retirement: advice for physicians. JAMA 1977;238(2):149-51.
5. Virshup B, Coombs RH. Physicians' adjustment to retirement. West J Med 1993;158(2):142-4.
6. Brooke N. The effects of retirement. Aust Fam Physician 1980;9:576-8.
7. Dunkel PL. Gearing up for retirement. Iowa Med 1988;78(12):564-5.
8. Sharon IC. Don't be afraid to retire. Postgrad Med 1987;81(8):117-20.
9. United States Bureau of the Census. Statistical abstracts of the United States: table 116. Washington, D.C.: Government Printing Office, 1993:85.
10. Portnoi VA. The natural history of retirement: mainly good news. JAMA 1981;245(17):1752-4.
11. Veninga R. Finding success and happiness in retirement: planning is the key. Minn Med 1992;75(8):7-10.

Is Your Practice Ready For Age-Weighted Profit Sharing?

The following table shows how a discretionary contribution Age-Weighted Profit Sharing Plan can be used alone or in conjunction with 401(k) salary deferrals to help physicians of varying ages attain their tax sheltering goals:

	Age	Wage	401(k)	Age-Weighted Profit Sharing	Total
Physician 1	55	\$150,000	0	30,000	30,000
Physician 2	45	150,000	9,240	13,309	22,549
Nurse	35	40,000	616	1,570	2,186
Staff	30	25,000	385	750	1,135

Sletto & Associates, P.A., is a law firm whose attorneys practice exclusively in the area of employee benefits by providing consulting, plan design and administrative services. For a sample design study contact:

Sletto & Associates, P.A.

Employee Benefits Attorneys
2600 Eagan Woods Drive, #450
Eagan, MN 55121-1152

Practice limited to ERISA since 1988
Tel: 612-452-9322
Fax: 612-452-9355

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice OB/GYN Urgent Care Internal Medicine

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338



Laparoscopic-assisted Hysterectomy in a Rural Minnesota Hospital

Charles A. Tietz, M.D., F.A.C.O.G.

ABSTRACT

Hysterectomy remains a commonly performed gynecologic surgery. An estimated 650,000 women in the United States undergo surgical removal of the uterus annually at a considerable cost to patients, payers, and society at large. Currently, two-thirds of hysterectomies are performed by abdominal surgery and approximately one-third by vaginal surgery. Most research supports laparoscopic-assisted hysterectomy as a safe, effective, and less intrusive alternative to open surgery. Laparoscopy is far less costly, results in less pain, and has a much shorter recovery period. This paper discusses such advantages of the laparoscopic approach over the standard abdominal hysterectomy and reviews 158 laparoscopic-assisted hysterectomies performed at a 100-bed rural Minnesota hospital. Techniques, equipment, patient mix, and complications are discussed. Patients experienced few complications, and most left the hospital in 48 hours.

As demonstrated by the following report, laparoscopic-assisted hysterectomy is a beneficial alternative to standard hysterectomy and can be safely performed in a rural setting, allowing the patient and family to stay in their local communities. The benefits of laparoscopic-assisted hysterectomy over open surgery include the following:

1. one- to two-day hospital stay for the patient undergoing laparoscopic-assisted hysterectomy versus four to five days for abdominal hysterectomy;

2. two to three weeks out-of-hospital convalescence versus five to eight weeks for the abdominal hysterectomy patient; and

3. less blood loss, lower infection rate, less pain, smaller incisions, a more cost-effective surgery, less morbidity, and a lower mortality rate as compared with abdominal hysterectomy.

"Laparoscopic-assisted vaginal hysterectomy" and "laparoscopic hysterectomy" are not variations of vaginal hysterectomy. Although the pelvic contents are removed vaginally in the former procedure, most dissection and critical surgery is performed laparoscopically. The indications and contraindications for laparoscopic-assisted hysterectomy are the same for standard hysterectomy except that laparoscopic-assisted hysterectomy is contraindicated in invasive cancer of the cervix, invasive uterine cancer, ovarian cancer, acute pelvic infection, excessively enlarged uterus (larger than that of a 14-week pregnancy), and for other abdominal malignancies, as well as for patients who present with compromised heart and lung function.

This article reviews 158 laparoscopic-assisted hysterectomies performed at the Virginia Regional

Medical Center, a 100-bed hospital in Virginia, Minnesota.

METHODS

The patients ranged in age from 24 to 61 years. Weight range was 123 to 268 pounds. All patients presenting with abnormal uterine bleeding underwent transvaginal ultrasound, office hysteroscopy, and endometrial sampling. Those who did not respond to medical therapy, such as oral contraceptives or cyclic progesterone, were offered the surgical option of endometrial ablation or laparoscopic-assisted hysterectomy and/or vaginal hysterectomy when appropriate. Pelvic pain, large leiomyomata, adenomyosis, and endometriosis were the primary indications for hysterectomy (see Table 1). All patients with pelvic pain had undergone laparoscopy some time before the laparoscopic-assisted hysterectomy. About one-half of the patients had experienced previous abdominal surgery (see Table 2). The decision to perform hysterectomy for fibroids was based on the fibroids' size and growth and the patient's pain and bleeding.

Laparoscopic-assisted hysterectomy should be performed only under general anesthesia in a fully equipped operating room with the capability for laparotomy immediately available. I counseled all patients preoperatively and prepared them for laparotomy in case it became necessary in the course of the operation. I also discussed the alternatives and options to laparoscopic-assisted hysterectomy and the hazards of hemorrhage, infection, and urinary tract injury, including fistula and bowel injury. Finally, I reviewed potential cardiovascular and pulmonary complications.

A Foley catheter was placed in

the bladder and a uterine manipulator in the uterine cavity. After establishing a pneumoperitoneum, I inserted a 10 mm umbilical trocar, a right and left lower quadrant 5 mm

trocar, and a suprapubic 12 mm trocar. The laparoscope and video equipment were inserted through the 10 mm site; suction irrigation, grasping forceps, and bipolar forceps through the 5 mm sites; and stapling device through the 12 mm site.

The blood supply of the uterus and the adnexa, if they were to be removed, were coagulated and stapled down to at least or below the uterine vessels. Upon removal of the pelvic contents vaginally, the abdomen was re-insufflated, and all surgical sites were inspected laparoscopically.

Most patients were discharged in 48 hours, some in 24 hours, and some in 72 hours. Patients were instructed to report any heavy vaginal bleeding, any unusual abdominal or

pelvic pain, or fever in excess of 100° oral temperature.

The laparoscopic-assisted hysterectomy contrasts significantly with the standard abdominal hysterectomy not only because it is done with the aid of the laparoscope, but also because a variety of techniques can be used to ligate pedicles. These include stapling devices, endoloops, unipolar and bipolar scissors and cautery, and intracorporeal suturing. Most abdominal hysterectomies are restricted to clamping, cutting, and suturing techniques.

Four types of laparoscopic hysterectomy are defined in terms of the extent of the surgery executed laparoscopically as described below:

Type I: adhesolysis and adnexal and/or IP ligament dissection;

Type II: broad ligament dissection, including transection of the uterine arteries;

Type III: partial cardinal ligament dissection; and

Type IV: total hysterectomy (including removal of contents through trocar).

RESULTS

The results of this series of hysterectomies are outlined in tables 1 to 7 (see page 52 for tables 6 and 7). Six laparoscopic failures occurred in the first 50 cases, and none after that. "Failures" are defined as planned laparoscopic procedures abandoned because of pathology and/or unexpected degree of difficulty requiring standard abdominal hysterectomy. Although I took on more complex cases as my experience and confidence grew, the number of laparotomies did not increase as I would have expected. Two patients, both in the first 50 cases, required transfusions. This was a result of my using two 12 mm trocars in the lower quadrants. Transfusions were eliminated when I instead used a single midline 12 mm trocar.

The two patients with focal adenocarcinoma of the endometrium had negative preoperative office hysteroscopies and endometrial biopsies. The pathologist found the focal stromal carcinoma after performing a

Table 1

Indications for surgery

	Cases
Uterine myomata	67
Pelvic pain	22
Menorrhagia, metrorrhagia	35
Adnexal/pelvic mass	8
Endometriosis	26

Table 2

Surgical history

	Cases
Previous laparotomy	29
Previous laparoscopy	24
C-section	15

Table 3

Pathology

	Cases
Myomata	75
Endometriosis	26
Adenomyosis	29
Adhesive disease (pid, etc.)	3
Endometrial polyps	6
Hyperplasia	19
Focal stromal sarcoma	1
Focal microscopic adenocarcinoma	2

Table 4

Major complications

	Cases
Hemorrhage resulting in transfusion	2
Ureter injury	0
Bladder injury	0
Bowel injury	0
Cardiovascular	0
Embolus	0

Table 5

Minor complications

	Cases
Fever >101° >12 hours	13
Nausea/vomiting >12 hours	4
Ileus >24 hours	2
Ileus—readmit after 24 hours	1
Trocar (large) injury	
1. bleeding	2
2. hernia post-op	0

HYSTERECTOMY cont. on page 52

ANNOUNCEMENTS

• • • • •

ALLINA'S NETWORK STRATEGIES

Tuesday, January 16, 1996
7 a.m. to 9 a.m.
Sheraton Midway

This educational forum will be sponsored by the Minnesota Medical Association, Hennepin Medical Society, and Ramsey Medical Society.

Watch your mail for more details or call 612/623-2885.

• • •

GUNYOU IS APPOINTED CHAIR OF HEALTH CARE COMMISSION

Gov. Arne Carlson has appointed John Gunyou chair and consumer member of the Minnesota Health Care Commission, replacing Tom Swain, who resigned in July. Gunyou is the chief financial officer of the Minnesota Communications Group, a telecommunications holding company for a 28-radio-station system. Before joining Minnesota Communications Group, Gunyou was the commissioner of the Minnesota Department of Finance. He has also been the city finance officer for the city of Minneapolis and a financial and economic consultant for BBC Research and Consulting in Denver, Colorado. Gunyou's term on the commission expires June 30, 1997.

• • •

SCANDRETT IS EXECUTIVE DIRECTOR OF HMO COUNCIL

Michael Scandrett has been named executive director of the Minnesota Council of HMOs. Scandrett, the former executive director of the Minnesota Health Care Commission, has been working as an attorney and health care consultant with the Minneapolis law firm of Popham, Haik, Schnobrich and Kaufman, Ltd. He will continue to maintain a limited affiliation with the law firm's health care practice.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Calls for Geographic Equity in Medicare Bill

As *The Monitor* goes to press, a conference committee is reconciling the differences between the House and Senate versions of the Republican balanced budget bill, which calls for major changes in Medicare and Medicaid. The AMA has endorsed the House bill, which includes many reforms the association has sought for years.

Similarities Between House and Senate Bills

Both the House and Senate bills would cut Medicare growth by about \$270 billion between 1996 and 2002. Both proposals would allow Medicare recipients to choose between traditional fee-for-service Medicare and MedicareChoice—a variety of managed care arrangements, including HMOs and PPOs. Both would raise Medicare premiums and would introduce “affluence testing,” requiring the high-income elderly to pay a larger share.

Both bills would create a single conversion factor to determine physician payment and would replace the Medicare volume performance standard with targets based on the gross domestic product. Balance billing to Medicare recipients would continue to be limited to 115 percent in the fee-for-service market. (In Minnesota, no balance billing to Medicare patients will be permitted after January 1996.) In the MedicareChoice market, however, there would be no limits on balance billing. It is not clear whether Minnesota's “no balance billing law” would apply to MedicareChoice.

Reforms Are in House Bill

The differences between the House and Senate bills are significant. Democratic Rep. Martin O. Sabo, representing Minnesota's fifth district, is one of the conferees who is reconciling differences between the House and Senate budget bills. The MMA has urged Sabo to support the following reforms that are in the House but not the Senate bill:

- A reduction in the geographic disparities in Medicare capitated rates. The House bill would set a floor of \$300 for the adjusted average per capita cost (AAPCC), the Medicare capitated rate. Currently, 74 Minnesota counties fall below the \$300 capitation rate, so the House provision would be a step toward geographic equity. The AAPCCs are different for each county and are based on fee-for-service expenditures. Nationally, capitation rates for Medicare HMOs vary widely, from \$177 to \$678 per Medicare enrollee.

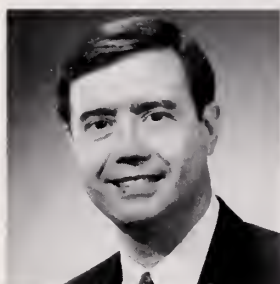
- Antitrust relief to permit formation of provider-sponsored networks (PSNs) to serve Medicare patients.

- Patient protections, including required disclosure of utilization review plan policies.

- Regulatory relief for physicians through reform of the Stark I and Stark II laws on self-referrals and easing of CLIA rules dealing with tests performed in physicians' offices.

- Medical liability reform measures, including a \$250,000 cap on non-economic damages.

Medicare continued on page 35



Viewpoint

• • •

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Public Health Is High on MMA Agenda

"To develop and maintain an environment in which physicians are able to deliver appropriate patient care and promote public health."

—Mission statement of the Minnesota Medical Association.

As chair of the MMA Board of Trustees, I often wonder how the MMA can best serve Minnesota physicians and whether our mission statement truly reflects what physicians want from this association. Do physicians really become MMA members because the association fosters an environment in which we can "promote the public health"?

This question was answered unequivocally at the 1995 MMA Annual Meeting when the MMA House of Delegates adopted 12 resolutions dealing with public health issues. Physicians from all regions of the state, who represent a wide range of specialties and practice arrangements, spoke out clearly and reaffirmed that public health is a high priority for the MMA. Our MMA public health efforts include public education and legislative initiatives that promote access to health care as well as public safety.

The MMA continues its strong support for access to necessary medical services for all Minnesotans. In light of the impending federal cuts and a decrease in money for government-funded programs, this will be a

challenging issue. The MMA House of Delegates passed a resolution reaffirming MMA support for a broad-based funding source for the MinnesotaCare program, which serves low-income families, rather than the narrow 2 percent provider tax and the \$400 medical license surcharge. Public funding is needed to provide access to medical care for Minnesotans who cannot afford it.

The MMA continues to pursue its highly successful communications efforts to promote public health. The MMA "Stop the Violence" campaign has been greeted with accolades and has raised public awareness of the danger to children of watching hours of violence on television and in the movies. By the time most young people graduate from high school, they have seen more than 200,000 acts of media violence. The MMA also continues to urge victims of abuse to ask their physicians for help in escaping the cycle of domestic violence and gives physicians a list of resources and referral numbers.

Encouraging corporate responsibility is another MMA communications goal. Recently, the MMA urged the G. Heileman Brewing Company to pull its ads linking sex and alcohol. Ads with slogans such as "Men Think About Ex 100 Times a Day" send the wrong message. Public health dangers include overuse of alcohol, teenage pregnancy, and sexually transmitted diseases.

In addition to our ongoing com-

munications efforts, the MMA will pursue the following legislative goals to improve the public health:

- Increase the tobacco tax.
- Ban smoking within 75 feet of a building designated smoke-free.
- Tighten handgun control laws and require guns to be locked if children under age 18 are present.
- Mandate life jackets for children.
- Support insurance coverage for childhood immunizations.
- Mandate bicycle and snowmobile helmets.
- Continue the fireworks ban.

Some critics charge that physicians should not be involved in mandating safety measures. I disagree. Preventive health is our responsibility. It is painful for us to see our patients suffer—particularly when the injuries or illnesses are preventable. Physicians are saddened to see patients die because of diseases caused by smoking or the overuse of alcohol. In the emergency department, I treat teenagers who are killed or who will spend the rest of their lives in nursing homes because of senseless violence. A pop culture that glorifies tobacco, alcohol, sex, and gunfire creates an unhealthy environment. Guns are readily available. Clearly, our society has serious problems that physicians cannot solve, but we *can* make a difference. Public safety laws do prevent illness and injury. For example, Canada's high cigarette taxes keep teenagers from becoming addicted to nicotine.

Surveys show that patients listen when we physicians give advice. This gives us a unique opportunity to encourage healthy lifestyles. We promote the public health when we ask such questions as: Do you have a gun in your home? Is it locked up so children cannot get it? Do you smoke? Does your partner ever hit you? As individuals and through our professional association, we educate the public and pursue legislation that promotes the public good.

I am proud to be part of this organization of Minnesota physicians who have made public health such a high priority. • • • • •

Medicare continued from page 33

The reform provisions in the House bill are under sharp attack. Insurance companies are aggressively lobbying the conference committee to drop the antitrust provisions that would enable physicians to form PSNs to serve Medicare recipients. Insurers also oppose House provisions that would set federal solvency requirements for PSNs that are more lenient than those for insurance companies. Consumer organizations are urging conferees to strike the House provisions that would exempt physician offices from CLIA requirements. The trial lawyers have mounted an all-out attack on the medical liability reforms.

Conference Bill Predictions

The situation remains extremely fluid, but the AMA speculates that the following provisions will be included in the conference committee bill: antitrust provisions that would allow the formation of PSNs, regulatory relief and CLIA reforms, and patient protection measures. It is unlikely that the medical liability reform measures will make it into the final conference bill, but Republican leaders may introduce separate legislation to cap non-economic damages. The conference bill is expected to call for one conversion factor; a "fail-safe" mechanism that would reduce payments to doctors and hospitals if the annual budget targets were not met; a MedicareChoice option of a medical savings account coupled with a catastrophic insurance policy; a cut in graduate medical education funds and creation of a GME trust fund with money from the general fund as well as from Medicare.

President Clinton is expected to veto the GOP conference committee bill, setting off a new round of negotiations. For the latest news on Medicare legislation, call the AMA hotline at 800/833-6354. •••••

Minnesota Will Lose Federal Medicaid Money

The House-Senate conference committee on the balanced budget bill is trying to reach agreement on ways to restructure the Medicaid program. In a major shift in the nation's philosophy, both the House and Senate bills would repeal the 1965 Medicaid entitlement program and replace it with block grants to the states. Both proposals would limit the rate of growth to 2 percent, but the Senate bill would move much faster toward that goal. The Senate bill would achieve the 2 percent growth limit in 1998, and the House bill would achieve the limit in 2000. Over a seven-year period, Minnesota would lose about \$2.9 billion under the Senate plan and about \$3.4 billion under the House plan. Medicaid expenditures in Minnesota have been growing by about 10 percent each year. The House bill would allow states to cover people with incomes up to 300 percent of the federal poverty level (\$22,410 for an individual); the Senate plan would

allow states to provide coverage up to 250 percent of poverty (\$18,675 for an individual).

The Minnesota Department of Human Services has been preparing for the expected loss in federal money and is proposing the following steps:

- Merge Medical Assistance, General Assistance Medical Care, and MinnesotaCare.
- Purchase rather than deliver services.
- Expand the use of managed care.
- Pursue competitive bidding.
- Cap enrollment in all three state programs at 600,000.

The MMA Ad Hoc Task Force on Medical Assistance, chaired by Timothy Crimmins, M.D., is also considering ways to cope with the loss of federal money. The MMA plans to work closely with the Minnesota Department of Human Services in an effort to maintain a safety net for the needy. •••••

Answers to Your CLIA Questions Are Just a FAX Away

••••• BRIEF BUT COMPREHENSIVE answers to office laboratory questions and information on the Clinical Laboratory Improvement Act (CLIA) regulations are available free of charge via same-day FAX through the Commission on Office Laboratory Accreditation (COLA). Thirty-three CLIA fact sheets condense information from a variety of sources such as the *Federal Register* and laboratory manuals into a user-friendly, one- and two-page format. Fact sheets cover such topics as quality assurance, quality control, proficiency testing, personnel standards, CLIA, and other laboratory requirements. This

unique service, made possible through a cooperative agreement with the Centers for Disease Control and Prevention, is available to physicians and their staffs by calling COLA Customer Service at 800/298-8044.

COLA is a nonprofit, physician-directed education and accreditation organization for the office laboratory. COLA's program is approved by the Health Care Financing Administration, and COLA-accredited labs are recognized as meeting all CLIA requirements.

MINNESOTA CARE NEWS

HTAC ISSUES PRELIMINARY REPORT ON ELECTRONIC FETAL MONITORING, PLANS TO EVALUATE POSTPARTUM STAYS

The Health Technology Advisory Committee (HTAC) of the Minnesota Health Care Commission has completed its preliminary report on the evaluation of electronic fetal monitoring versus intermittent auscultation for monitoring fetal heart rate during labor. A summary of HTAC's conclusions and recommendations was published in the October 9 *State Register*. A copy of the full preliminary report may be obtained by calling the Minnesota Health Care Commission information line at 612/282-6374. Any questions regarding the technology evaluation process should be

directed to Mary Fahey at 612/282-6355. The Minnesota Health Care Commission will accept public testimony on Wednesday, January 17, at 10:30 a.m. at the Capitol View Conference Center in Little Canada.

If you would like to obtain a copy of HTAC's completed reports on stereotactic radiosurgery—neurological applications; prostate specific antigen as a routine screening test for prostate cancer in asymptomatic men; and thrombolytic therapy for acute myocardial infarction, call the Health Information Clearinghouse at 612/282-6314.

Next on HTAC's agenda is an evaluation of postpartum hospital stays. HTAC hopes to complete its

evaluation of this controversial issue by the end of the year.

COMMISSION CONSIDERS WHETHER TO DEVELOP ISN RULES

The Minnesota Health Care Commission has formed an ad hoc committee to consider whether the Minnesota Department of Health should go forward with developing rules for integrated service networks. Last session the Legislature scrapped plans to develop a regulated all-payer option for all services not provided by ISNs. Without RAPO, the MDH may consider setting minimum quality standards for all health care delivery systems rather than developing rules just for ISNs.

Notice—Change in Growth Limits

• • • • • THE 1995 MINNESOTA Legislature made an important change to the growth limit provisions of the MinnesotaCare law. Effective in 1996, physicians who comply with the state growth limits by limiting their fees will be subject to a growth limit based solely on the regional consumer price index for urban consumers (CPI-U). The regional CPI-U is projected to be 3.1 percent for 1995, an increase over the CPI-U of 2.9 percent for the previous two years. The Minnesota Department of Health will publish the actual 1995 regional CPI-U by January 31, 1996.

Before the change enacted by the 1995 Legislature, provider fee increases could be based on the full growth limits applied to hospitals and health plans. The full growth limit is the CPI plus X percent. The X factor is set by law to reflect

increases in volume and intensity. The projected full growth limit for 1996 is 7.4 percent (3.1 percent estimated 1995 CPI + 4.3 percent, the X factor). The Department of Health argued that the change in the fee limit approach was appropriate because a limit on fees is a price limit not a volume control. Therefore, the volume "add-on" (the X factor) should not be included.

Physicians should consider their options in meeting the growth limits. The full growth limits can be applied to revenue per patient or revenue per encounter. If this information is not available, providers can consider limits on their fees.

Remember that physicians who comply with the growth limits through fee limits will be monitored on an annual basis. Revenue limits are based on a two-year average. Providers who wish to comply with the growth limits by using one of the

two revenue options should submit an adjustment methodology that takes into account such factors as case mix complexity, taxes and assessments, and payer mix. Providers may make changes to methodologies and/or change their means of compliance by submitting methodologies for 1996 and 1997 data by September 1, 1996.

If a provider exceeds the fee or revenue limit, the commissioner of health will notify the provider 30 days before taking any action. The provider will have 10 days to provide an explanation for exceeding the limit. Providers may appeal. A written notice of appeal is due within 30 days after the commissioner's order was mailed.

If the state determines that a provider has exceeded the revenue limit, the provider must pay back the amount in excess of the revenue limits to the Minnesota Health Care Access Fund. The payment is due during the following calendar year.

How Would the GOP Bill Affect Minnesota Docs?

The AMA believes that the GOP House bill included enough "sweeteners" to offset the cuts in Medicare growth. As negotiations continue, the association will continue to fight for these reforms. But even if all the Medicare reforms are won, will Minnesota physicians come out ahead? The jury is still out, but there are troubling indications that federal cuts may have a sharper effect in Minnesota than in some other states.

How Valuable Are the Reforms?

- The state of Minnesota will not allow physicians to balance bill Medicare patients who are Minnesota residents after January 1996, so the ability to bill actual charges in the MedicareChoice market may not benefit Minnesota physicians unless there is a change in state law or unless there is a legal clarification that the state ban only applies to the traditional fee-for-service Medicare market.

- Incentives for Medicare recipients to shift from fee-for-service to managed care may not work in Minnesota's rural areas. Even if the House provision is adopted that sets a floor of \$300 per enrollee as the capitated rate, this may not be enough to lure private HMO plans into rural Minnesota. In some areas of the country, Medicare enrollees are offered extra services such as prescription drugs and eyeglasses if they choose an HMO. But in Minnesota, where the capitation rate is low, there is not enough profit margin for Medicare HMOs to offer these benefits.

- Antitrust relief that enables physician networks to form would be a step in the right direction, but it would only apply to Medicare patients. It is not clear whether physician networks would form if they could only serve Medicare patients.

Negative Effects of Cuts

- Physician reimbursement for state programs may be reduced. Under the

Medicaid block grant proposal, Minnesota is expected to lose an average of \$400 million to \$500 million annually until the year 2002. As a result, the state may be forced to cut MA eligibility, cut medical services, and/or cut physician reimbursement.

- Demand for unpaid care may rise. To cope with the loss of federal money, the Department of Human Services has proposed capping the number of people in all three state programs: MinnesotaCare, Medical Assistance, and General Assistance Medical Care. Currently, there are about 550,000 people in these programs, and the cap would limit the number to 600,000 over the next seven years. It is projected that by 2002, the number of eligible persons would rise by 125,000. The cap could leave 75,000 needy people without state help in paying for medical care.

Physicians would have to choose whether to give unpaid charity care or to refuse to provide care.

The question is: Will the reform measures in the House bill be worth the loss in federal dollars to Minnesota physicians?

On the national level, if Congress cuts Medicare and Medicaid hospital and provider spending by \$210 billion, the result will be lower wages, higher out-of-pocket health care expenses, and an additional 523,000 uninsured by 2002, according to a study by Lewin VHI, conducted for the American Hospital Association in August. The study predicts that hospitals and providers would pass on spending cuts to the private market; as a result, employer health care spending would increase by \$75 billion, and workers would lose \$66 billion in wages. Employees' share of coverage would increase by \$6.4 billion, and individual policyholders would see a \$10.2 billion increase in their premiums, copays, and deductibles. • • • • •

AMA Counters Negative Publicity Over Support for GOP Medicare Bill

Addressing the MMA Board of Trustees on November 4, Lonnie Bristow, M.D., AMA president, criticized media coverage of the AMA's decision to support the GOP House Medicare bill. "The media has charged that the AMA made a sleazy, back-door deal with the GOP, but nothing could be further from the truth. Our negotiations could have been made in church on Sunday morning," Bristow told the board.

Bristow said that GOP leaders listened when the AMA explained why the initial House proposal of \$34.60 for a conversion factor was too low. The AMA explained that as a result of Medicare cuts over the past 13 years, physicians receive only 63 cents on the dollar for treating

Medicare patients. The overhead for physicians is 50 percent of their revenue. This means that physicians end up with 13 cents out of every Medicare dollar. "We wouldn't be able to afford to treat Medicare patients if the conversion factor were set too low. All we did was fight for access to care for our patients," Bristow said. The conversion factor is now set at \$35.42 in both the House and Senate bills.

Bristow admitted that the GOP bill is "not perfection," and said adjustments will have to be made. The willingness of House Majority Leader Newt Gingrich to leave the door open for further discussions was a key factor in the AMA decision to support the GOP bill. • • • • •

Buyers' Health Care Action Group Introduces Direct Contracting

The Buyers' Health Care Action Group, a powerful coalition of 24 employers including Dayton Hudson, General Mills, and 3M, will begin contracting directly with provider groups rather than with health plans starting in 1997. BHCAG will issue a request for proposals (RFP) by the end of 1995, and responses will be due by March 1996. The final selection will take place by the end of June 1996, and the new model of contracting will take effect in January 1997.

At a seminar sponsored by the Minnesota Medical Association, Hennepin Medical Society, and Ramsey Medical Society on November 8, Ann Robinow, BHCAG director of strategic planning, told an audience of providers, health care consultants, and clinic managers why BHCAG wants to introduce a new delivery model and what the employer group will be looking for in the new "care systems."

Why Stop Contracting With Plans?

Although BHCAG is sometimes credited with starting Minnesota's merger mania, BHCAG now believes market consolidation has gone too far, according to Robinow. With only three or four major players that have overlapping networks of providers, the distinctions among provider groups are blurred. There is no market advantage to the provider group in being efficient or providing exceptionally high quality. "Bigger multi-specialty clinics are not necessarily more efficient; they sometimes cost more," Robinow said.

"Direct contracting offers a way for smaller multispecialty groups to access the system without being bought," Robinow said. Practices would have to work together and be integrated in some way, but they would not have to be under a plan umbrella. "We want to turn decisions back to the medical communi-

ty," Robinow said. Currently, there is a lack of trust between employees and health plans, she said. Employers want to avoid having physicians tell patients that the blue pill is better, but their employer health plan will only pay for the pink pill. Direct contracting would put medical decisions back in the providers' hands, allow employees to choose their own physicians, and preserve the doctor-patient relationship.

If BHCAG is not satisfied with competition under the new contracting arrangement, it will have no alternative but to consider supporting a health care system that would be heavily regulated by the state, Robinow predicted.

Highlights of BHCAG's 1997 Model

The new contracting arrangement will have these features:

- Employers will pay for their employees to receive the medical services in a standard benefits set offered by an array of "care systems." There will probably be two benefit-level options.
- Employees will pay the cost difference among the various care systems.
- Care systems will compete for patients on the basis of cost, quality, and service.
- Provider payment will be based on a fee schedule adjusted to reflect the care system's success in meeting its claim target.
- Retrospective risk adjustment will prevent care systems from being penalized for having a sicker population of patients.
- BHCAG will designate some Centers of Excellence.
- BHCAG will provide most administrative services, such as claims processing, customer service, and education.
- Care systems will be expected to perform continuous quality improvement and utilization review.

The care system may contract for these services.

What Is a 'Care System'?

A "care system" is a provider group with a primary care focus that offers a full continuum of care. "There is no right way to form a care system," Robinow said. "BHCAG will contract with whoever can provide the best quality and service. Price efficiency will be passed on to consumers, who will consider cost in their selection of care systems." Decisions about gatekeeping, which guidelines to follow, and other managed care techniques will be up to the care system. She suggested three possible models:

- 1) provider-hospital organizations;
- 2) large health care systems such as Park Nicollet or Mayo; or
- 3) physician organizations that contract for specialist and hospital care.

Specialists will contract with various care systems. Primary care providers will be able to participate in only one BHCAG care system.

How Big Should a Care System Be?

"There is room at the table for all kinds of arrangements," Robinow said, but added that BHCAG would prefer smaller groups that create intellectual ownership at the provider level. A care system shouldn't be too small. It would need at least 2,000 patients in order to generate statistically valid information, Robinow said. Accountability is important.

'Virtual Capitation' Maintains ERISA Protection

Maintaining their ERISA protection as self-insured employers is important to BHCAG members, who operate in different states and do not wish to be subject to varying state taxation and regulation of their employee benefits plans. Because capitation would put BHCAG outside ERISA's circle of protection, BHCAG has designed a hybrid it calls "virtual capitation." Employers pay each individual claim as they

would in a fee-for-service arrangement, but the provider fee schedule is based on the care system's success in meeting its claim target, the care system's estimate of the cost of providing care per member per month.

Care Systems Will Set Claim Targets

In its RFP, BHCAG will define its standard benefits set and tell prospective care systems the historic range of costs of providing that set of benefits per member per month. Each care system will submit bids called "claim targets." BHCAG expects eight to 10 bids in its first response. Employees will pay the price difference among the care systems' claim targets. For instance, if the employer contributes \$100 per month and the employee chooses a provider whose claim target is \$110, the employee pays \$10 per month. This system will return competition to the patient/provider level. A care system might bid low to attract a greater market share if it believes it is efficient enough to provide care for that price. Care systems that bid high will have to provide quality and services that justify the higher cost to the employee, or they may not survive in a competitive market.

BHCAG will compare each care system's claims performance with its target bid and will move the providers' future reimbursement up or down accordingly. The goal is to bring actual experience in line with the claim target. For a standard patient population, if the care system's claims are lower than the claim target, the fee schedule conversion factor will be higher in the next quarter. If the claims are higher than the target, the fee schedule will be lower. There will be no retrospective recovery or payment of money. The care system will be paid for all the services provided. Since the claims target is based on a standard population of patients, retrospective risk adjustment will be used to make sure a care system is not penalized for serving a sicker population of patients. It is important that the risk adjustment be retrospective, Robinow said. "Hind-

MMA Calls on G. Heileman Brewing Company to Pull Ads for Ex Beer

The MMA urged the G. Heileman Brewing Company to pull its Ex beer ads linking sex and alcohol. The advertising campaign, which uses slogans such as "Men Think About Ex 100 Times a Day," blatantly uses sex to sell alcohol. Public health dangers include overuse of alcohol, teenage pregnancy, and sexually transmitted diseases. The MMA cited these statistics:

- The United States has the highest rate of teenage pregnancy in the industrialized world.
- The average age for an adolescent to use alcohol for the first time is 13.
- By age 15, 33 percent of American boys have had sexual experience.

An article by Gordon Slovut, which appeared on the front page of the *Twin Cities Star Tribune*, explained why suggestive ads send teens the wrong signals. The article quoted Michael Murray, M.D., president of the MMA, and Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees. Murray said that although ads have long used sex to sell products, the Ex beer campaign crosses the line. Crimmins told the newspaper that the MMA's opposition to ads that encourage teenage drinking and sex fits in with the association's campaign against guns and domestic violence. He was quoted as saying, "We are not talking about censorship. We are encouraging corporate responsibility." • • • • •

sight is 20/20."

One participant suggested that BHCAG consider the number of employee sick days when they evaluate the care systems. The value of preventive care shows up in a more productive work force.

Where Do Health Plans Fit In?

"The role of health plans is evolving," Robinow said. BHCAG will buy administrative services from the health plans. In addition, care systems might contract with the plans for help in becoming more efficient. For instance, they might ask the plans how they can reduce their number of inpatient hospital days.

What Are the Legal Obstacles?

Robinow stressed that it is the care system's responsibility to avoid legal problems as they integrate small group practices into a care system. Discussions about prices raise potential antitrust problems. Robinow recommended that providers who are considering forming a care system talk to an attorney in order to

avoid the risk of price-fixing charges. The MMA and AMA legal staff are currently involved in an analysis of these issues.

MMA Offers Direct Contracting Education

Watch for the February issue of *Minnesota Medicine*, which will include a number of articles on direct contracting. In addition, the Minnesota Medical Association and Hennepin and Ramsey medical societies will offer an educational forum, "The Network Strategies of Allina," January 16 at the Sheraton Midway. Watch your mail for more details, or call 612/623-2885. Future direct contracting workshops will discuss coding, the use of guidelines, and the use of computer systems for providing quality and cost data. Proper diagnosis coding will be extremely important in direct contracting arrangements with BHCAG. • • • • •

LEGAL NEWS

**APPEALS COURT OVERTURNS
MONOPOLY VERDICT AGAINST
MARSHFIELD CLINIC**

A federal appeals court overturned a jury verdict that the Marshfield Clinic had created an illegal monopoly that squeezed Blue Cross and Blue Shield United of Wisconsin Inc. out of some areas of the state.

The 7th U.S. Circuit Court of Appeals found that the Marshfield Clinic did not hold a monopoly in north-central Wisconsin, and then added that even if a monopoly did exist, it would be a "natural" monopoly and, thus, not illegal.

Judge Richard Posner stated, "If an entire county has only 12 physicians, one can hardly expect or want them to set up in competition with each other. We live in the age of technology and specialization in medical services. Physicians practice in groups, in alliances, in networks, utilizing expensive equipment and support. Twelve physicians competing in a county would be competing to provide horse and buggy medicine. Only as a part of a large and sophisticated medical enterprise such as the Marshfield Clinic can they practice modern medicine in rural Wisconsin."

The appeals court also ruled that an HMO did not constitute a separate market and that Marshfield and its Security Health Plan HMO could not have conspired to prevent Compcare—the Blue Cross HMO—from doing business with physicians in the area.

The appeals court did, however, uphold the jury finding that the clinic had conspired with competitors, particularly the North Central Health Protection Plan, to divide state markets and ordered a retrial on damages due to Blue Cross for that portion of the case. In the original trial, the jury had awarded \$48.5 million in damages to Blue Cross. U.S. District Judge John Shabaz of Madison upheld the jury

verdict but reduced the damages to \$17 million. The Marshfield Clinic then appealed. Ordering the retrial, Judge Posner of the appeals court wrote: "There must be a new trial limited to damages for dividing markets. The burden will be on Blue Cross to show how much less it would have paid the clinic had the clinic refrained from that illegal practice."

An amicus brief supporting the Marshfield Clinic was filed jointly by the American Medical Association, the Medical Group Management Association, and the State Medical Society of Wisconsin.

**MEDICARE SUPPLEMENT PLAN
REQUIRED TO COVER DIABETES**

A new law requires Medicare supplemental insurance plans to cover the supplies and equipment necessary for the treatment of diabetes. This expands the language in previous law that required health plans to cover "all physician-prescribed, medically appropriate and necessary" equipment and supplies used in the management and treatment of diabetes. The change in law takes effect for plans issued or renewed on or after January 1, 1996.

In Minnesota, 45 percent of the 104,000 people diagnosed with diabetes are people aged 65 or older, many of whom depend on Medicare supplemental plans for their health insurance coverage. According to the Minnesota Chapter of the American Diabetes Association, this new law will make it easier for the elderly to afford the preventive testing and management supplies needed to control their diabetes and to reduce their risk of developing complications.

"This new law will greatly improve access to appropriate medical care for persons with diabetes," said Jim McGowan, chair of the government

relations committee of the American Diabetes Association. "Accepted standards of care for diabetes ought to be covered by insurance policies."

**PIPEFITTERS' ERISA CHALLENGE IS
DEFEATED**

The 8th U.S. Circuit Court of Appeals affirmed a Minnesota District Court ruling that Minnesota's 2 percent provider tax does not violate the Employee Retirement Income Security Act (ERISA) or the Labor Management Relations Act. The Twin Cities Trades Welfare Trust had argued that health care providers could not pass on the 2 percent tax on to self-insured health plans without violating ERISA, the federal law protecting employee benefit plans. In addition to finding that federal law does not pre-empt the provider tax, the court ruled that the pipefitters' union did not have standing to challenge the MinnesotaCare legislation's data reporting provisions or spending cap provisions.

The Monitor
DECEMBER 1995

PRESIDENT

Michael J. Murray, M.D.

CHAIR, BOARD OF TRUSTEES

Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER

Paul S. Sanders, M.D.

DIRECTOR OF COMMUNICATIONS

Mark S. Vukelich

EDITOR

Lorrie Holmgren

I would like to learn more about what
MMBR Motor Services can do for me
on the lease/purchase of my next vehicle.

Name _____

Address _____

City _____ State _____ Zip _____

Please contact me at my ☐ Home ☐ Office

Phone number _____

I plan to ☐ lease ☐ purchase a new vehicle

Within ☐ 3 months ☐ 6 months ☐ 12 months

MNMD



POSTAGE
NECESSARY IF
MAILED IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761

Check it out! Special pricing on new 1996 models through MMBR Motor Services.



Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or

purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.



1996 Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
Honda Accord 4Dr LX	\$20,220	\$18,510	\$318	\$287	\$267	\$251
Toyota Camry 4Dr LE	\$21,938	\$19,544	\$307	\$287	\$274	\$269
Ford Taurus 4Dr LX	\$22,390	\$20,600	\$411	\$377	\$343	\$320
Chevrolet Suburban 4x4 LS	\$35,838	\$32,819	\$510	\$487	\$452	\$433
Dodge Grand Caravan LE	\$27,880	\$25,555	\$475	\$415	\$382	\$352
Toyota Corolla 4Dr DX	\$18,010	\$16,288	\$319	\$283	\$267	\$253
Ford Explorer XLT 4Dr 4WD	\$28,835	\$26,200	\$419	\$389	\$363	\$344
Honda Civic 4Dr LX	\$16,230	\$14,955	\$256	\$231	\$208	\$206
Mercury Sable LS	\$22,780	\$21,075	\$436	\$388	\$352	\$327
Jeep Grand Cherokee Laredo	\$30,199	\$27,751	\$477	\$419	\$398	\$385

* Sale price before tax, license, and license fees. Prices and lease rates are subject to change due to adjustments made by manufacturers and finance companies.

** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a \$0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.

MMBR
MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*



Columbia Park Medical Group

• BC/BE Specialists

ALLERGY AND IMMUNOLOGY: Join two-member department of adult and pediatric allergy practice with clinical studies and interest in academia.

FAMILY PRACTICE: Join group or do Urgent Care with a 29-member Family Practice Department with call one weekday per month and one weekend day per month.

INTERNAL MEDICINE: Nine-member department has busy hospital and clinic practice.

OB/GYN: Three B.C. physicians seeking fourth to join their busy practice.

OCCUPATIONAL MEDICINE: Three B.C. physicians looking for additional physician to join busy Occupational Health Department.

PEDIATRICS: Seeking fourth pediatrician interested in primary and consultative pediatrics.

Columbia Park Medical Group is a physician-owned multispecialty group. The 60-physician practice is in three sites located in the northern Minneapolis suburbs. Excellent salary and benefits package. Ownership after one year is offered. Send C.V. to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Fridley, Minnesota 55432
Stephanie Clark (612) 586-5876

Internist...

Want to share call with 8 other Internists and live in the Brainerd lakes area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30-physician independent multi-specialty group
- Located in a primary service area of 40,000
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Inquiries from Internists with subspecialty interest in Pulmonology and Rheumatology welcomed.

Call collect to administrator:

- Curt Nielsen
218-828-7105 or
218-829-4901
2024 South 6th Street
Brainerd, MN 56401



ASSOCIATE MEDICAL DIRECTOR

HealthPartners' Government Programs • Minneapolis, Minnesota

HealthPartners is one of Minnesota's largest health care organizations, providing health care coverage and services to more than 600,000 members.

We're currently seeking an Associate Medical Director for Government Programs to assure that these program members' needs are optimally served.

This leadership role develops quality and utilization programs; provides data to measure results; assists with education and professional development of medical services staff; assures implementation of utilization programs; contributes to team and community building and participates in strategic direction of HP's government programs.

We're looking for candidates who are board certified, willing to practice on a limited basis,

have or are willing to obtain a Minnesota license, and have five years' full-time experience in clinical practice. In addition, our ideal candidate will have interest and experience in caring for publicly funded patients and a background in medical administration-management.

We offer a competitive salary and comprehensive benefits package. For consideration or more information, please call Bev Friedrichs, (612) 883-5323, or send CV to HealthPartners, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309.



HealthPartners

HealthPartners' mission is to improve the health of our members and our community.

Three to Get Ready: Taking EDI from Theory to Reality

Implementing an EDI system takes knowledge and planning, as with any computer system. These steps will help get you going. Last of three parts.

Sue Chapin-Strike

So you've decided to implement electronic data interchange (EDI) to speed the flow of data between your clinic and other health care organizations. Now what? As with any other computerized system, planning and communication are critical. Following are nine steps to guide you through the process.

If you missed the last two issues of *Minnesota Medicine*, you may be wondering just what EDI is. The first article of this series, "One for the Money: The Financial Benefits of EDI" (October 1995, page 52), tells how EDI can improve an organization's cash flow. The second article, "Two for the Show: The Vision of EDI and Electronic Commerce" (November 1995, page 59), details EDI's many uses, such as processing claims and transmitting purchase orders. Once you're convinced of EDI's value, follow these steps to implement your own system.

1: PUT TOGETHER A TEAM

Once it's implemented, EDI will affect every aspect of your organization. Put together a team with a mix of skills. Include representation from a number of functional areas, such as business administration, legal, and auditing—either staff members or outside contracted personnel. Remember, not all members of the team need to participate the entire time, but all members need to participate. It's critical to include the following people:

- the business manager;
- operations staff, i.e., employees who code, key-punch, reconcile payments, and file;
- all departments that exchange data with outside organizations;
- systems personnel responsible for project management;
- computer programmers;
- legal counsel (for advice on issues of confidentiality, security, and agreements with trading partners); and
- financial and systems auditors.

After assembling the team, it's critical to choose the team leader. This person must have decision-making

authority, ownership of the project, and the energy and enthusiasm to keep the project moving.

2: EDUCATE, COMMUNICATE

Begin the project by educating the entire team about EDI—what it is, how it works, and why it's important to the organization. Make sure the organization's vision focuses on business (not technical) objectives and is easy to articulate. This is the first opportunity to set the stage for changes ahead.

Be prepared for naysayers, whose objections will be heard around the office: "It'll never work!" or "Start somewhere else—I'm too busy," or "We tried that before."

Some business activities necessary today will not be necessary after implementing EDI. For example, data entry for posting payments may be entirely eliminated. Anticipate employee concern over job security. Evaluate opportunities to reassign staff to areas that may add value to the organization and offer an opportunity for employees to increase their skills (for example, data entry staff could assist with collections).

3: DEVELOP A BUSINESS PLAN

Remember, EDI fulfills a business need, and the business plan is written in management terms, not technical terms. Look at the entire organization and identify opportunities; with whom do you exchange data? Analyze the costs associated with each exchange; how many hours are spent handling mail, sorting, posting, and filing? If all claims or encounter reports were sent electronically, how much money would the organization save in postage, paper, and filing? If laboratory results were communicated electronically, what would be the impact on decision-making and patient scheduling?

Use this opportunity to review the entire business process. Don't simply automate the existing process. Ask the staff who perform the day-to-day operations to think about what's needed to do their jobs more efficiently and effectively, and compare their responses with what's currently available. Is everything they handle necessary?

Could the process be improved with different or additional information?

Regarding costs, determine whether EDI will be treated as a utility function (like phone or fax) or implemented uniquely for each business area. This is a strategic decision that will influence your selection of hardware and software and your approach to communications.

Once the analysis is complete, establish priorities. Remember, you cannot eat an elephant in one sitting.

4: IDENTIFY THE FUNCTIONAL REQUIREMENTS

From a technical perspective, this is the most critical step. If necessary, an outside group can complete the documentation and execution, but it's imperative that the organization implementing EDI define the requirements.

Unless the organization has a document outlining functional requirements, success cannot be measured. Identify the applications, people, and processes involved. Detail the expected results. Determine the specific data requirements and the application system modifications. Resolve business, legal, auditing, and security issues. For example, if payments are moved electronically, what must be retained for the IRS? How long does electronic data need to be kept, and in what format? Who will have access to what data? What happens when system changes are made?

5: SPECIFY OPERATING REQUIREMENTS

Review and specify hardware, software, and communications requirements. There are many options from which to choose. In most cases, EDI is not dependent on the type of hardware platform. EDI software is available for personal computers, minicomputers, and mainframe computers; the primary difference may be price (ranging from \$600 to \$200,000).

The question of where to locate the EDI system depends on whether EDI is centralized or decentralized. Will a single EDI station communicate with all business areas handling claims, payments, eligibility, and purchasing? Or will EDI be implemented separately in each functional area? If separately, the vendors providing the application software to serve that business function may be able to make recommendations. If EDI is centralized, an expert will need to facilitate integration to each system.

Organizations implementing EDI must decide where communications control will reside. Will trading partners be able to initiate communications into your system, or will all communication flow be controlled from one site? To protect confidentiality, some organizations have systems in which all communications must be initiated from within the organization; no one can dial into the system. This type of arrangement may require use of a value-added network (VAN) with store and forward capability. The VAN serves as a trusted third party in the receipt and delivery of electronic data. A typical VAN supports all EDI transactions and connects with all other VANs (much like with long-distance phone carriers, e.g., Sprint users can call MCI users). VANs may provide

other services as well, such as conversion of EDI data to fax. They also may offer archival services. A word of caution: When selecting your communications service provider, thoroughly analyze the cost based on size, volume, and timing requirements.

An alternative to a VAN is a clearinghouse, which differs from a VAN in three ways: 1) Clearinghouses generally do not support the communication of all documents; they may be limited to claims and payments; 2) They generally provide an editing service to "scrub" the claim—that is, modify it to meet the receiving organization's requirements. Be sure you understand and are comfortable with the revisions that could be made; 3) They may be capable of connecting with only a limited number of trading partners.

Clearinghouses and VANs may charge a fee for each transaction and/or a fee based on the number of characters transmitted. Pricing also may be time dependent, with prime-time business hours being more costly.

A third communications option is a regional network or a community health management information system (CHMIS). Depending on how the CHMIS is organized, it may be capable of connecting with all trading partners in a particular area (such as a state or region) in a cost-effective manner based on an annual participation fee. Often the participants govern the CHMIS. As with clearinghouses, the types of documents supported and the connections with trading partners may be limited.

The final communications alternative is direct connection. This option may appear at first to be a low-cost alternative, but since there is no standard computer communications protocol, a different setup may be required for each connection. The setup, testing, and maintenance of multiple direct connections may be time-consuming and difficult to manage. Direct connections typically are used when a single trading partner represents an extremely high percentage of all of the data exchanged.

Finally, operating requirements include identifying the facility and personnel necessary to develop, maintain, and operate the EDI system daily.

6: REVIEW EDI STANDARDS AND CONVENTIONS*

Although Minnesota is moving in concert with the Health Care Financing Administration concerning the electronic transmission of claims and payments, some trading partners may have chosen other conventions. After reviewing priorities, organizations may choose to implement a transaction specific to a single trading partner, such as the interactive eligibility inquiry. Regardless of priorities, a technical development team will need to identify the standardized format for transmitting data.

*Minnesota's convention of use is now available for comment and review. Contact Denine Casserly at the Minnesota Department of Health, 612/282-5651, to receive the document in paper or diskette form; the document can also be downloaded from the Minnesota Health Data Institute's Web site at the following address: <http://www.mhdi.com>.

7: INTEGRATE AND TEST THE SYSTEM

The importance of integration cannot be overemphasized. If the EDI system is not integrated with the application system, it may become an incredibly expensive fax machine. Without integration, the data must be transferred to a hard copy, read, and rekeyed into the system, negating the value of EDI. Some vendors hamper integration by designing systems in which only they can perform the integration. In many cases, the addition of each trading partner may mean the addition of a new fee.

Integration of inbound data is more complex than the extraction of outbound data. For example, a remittance advice with one invalid item is easy to handle in the paper world; it can be marked as invalid, set aside until a solution is found, and then posted when corrected. The corrected copy is stapled to the original and filed to provide an audit trail. The same process needs to occur in the electronic system, but this may require modifications to the existing system.

Testing is also important to reduce system failures and provide for appropriate recovery when the inevitable occurs. What happens if someone inadvertently trips over the power cord and causes the system to crash? Is there a restart/recovery mode? What happens if the communications session is interrupted? How do you know whether the transmission was complete?

Integration is not complete until operating procedures have been created and operators have been trained.

8: TEST THE SYSTEM WITH TRADING PARTNERS

Now that the EDI system is up and running, it must be tested with trading partners. It's critical that both partners set aside time when testing is the priority. Too often, the testing cycle is spread out over weeks or months because the partners are busy with other tasks. If the organizations involved have reviewed documentation, and if the proper communications provider has been selected, the time for testing will be greatly reduced.

The groups should test what happens when communications are interrupted and determine how to handle incomplete or garbled transmissions. Both parties must assure that the exchange is complete, unaltered, and restricted to the intended party. Organizations may choose to encrypt data to assure confidentiality.

9: EXPAND THE SYSTEM

With success, it's time to move EDI from pilot to production. Analyze the pilot results before expanding the program to additional partners and/or transactions. What problems were encountered? How can they be avoided in the future?

Although the entire process may seem overwhelming at first, it is really no different from implementing any other computerized system. It simply requires knowledge, planning, and follow-through.

MM

Sue Chapin-Strike is director of the Minnesota Center for Healthcare EDI.

UPDATES IN OPHTHALMOLOGY AND OTOLARYNGOLOGY FOR PHYSICIANS

Saturday, January 6, 1996

7:30 AM — 2:00 PM

Minnesota World Trade Conference Center
400 Minnesota World Trade Center
St. Paul, Minnesota 55101

SPONSORED BY:

HealthEast  **St. Joseph's Hospital**

**There is no registration fee for this program.
TO REGISTER, PLEASE CALL 221-9849**

PRESENTED BY:

ST. PAUL EYE CLINIC, P.A.

OPHTHALMOLOGY—OPHTHALMIC SURGERY

*Otolaryngology & Head
and Neck Surgery, P.A.*



**Blue Cross
Blue Shield
Blue Plus**
of Minnesota

COMPLIMENTS
of
Your Local
Independently Owned
Hospital Equipment
and
Supply Company
serving
Doctors, Nurses,
Hospitals, Laboratories
and Nursing Homes

C. F. ANDERSON CO., INC.

10925 Nesbitt Avenue South
 Bloomington, MN 55437
 Local (612) 881-0618
 WATS (800) 328-6246
 FAX (612) 881-7297



C.F.
anderson
 COMPANY, INC.

Emergency Room Physician

Sauk Prairie Memorial Hospital, located 30 minutes north of Madison, Wisconsin, seeks a full-time emergency room physician to join two full-time ER physicians in expanding services. Must be BC/BE in family practice or other primary care field. Certification in ACLS/ATLS/PALS required. Our candidate must be interested in teaching, community involvement, and be willing to make a commitment in a beautiful geographical area that offers year-round recreation plus numerous opportunities for professional, educational, and cultural growth. Located in the Wisconsin River Valley, midway between Madison and Wisconsin Dells, we offer an up-to-date and modern 36-bed facility with an expanding young primary care and specialty medical staff. For confidential consideration, please send resume to:

Human Resources
 Sauk Prairie Memorial Hospital
 80 - 1st Street
 Prairie de Sac, WI 53578
 Equal Opportunity Employer

EMERGENCY MEDICINE
 P • S I T I • N S

IOWA
NORTH & CENTRAL MINNESOTA

- Full- and part-time
- Comprehensive benefit packages
- Paid malpractice
- Professional environments
- Ample time for family and leisure
- Progressive physician-owned group
- Excellent compensation packages
- Various locations
- Reasonable housing in safe communities
- Top-notch school systems
- Quality lifestyles

CALL 1-800 458-5003

Emergency Practice Associates
 or send CV to Sheila Jorgensen
 P.O. Box 1260, Waterloo, IA 50704

People and Places Making Medical News

People

.....

'U' Family Practice Head

William E. Jacott, M.D., has been appointed interim head of the University of Minnesota's Department of Family Practice and Community Health. Jacott, a professor in the department and assistant vice president of the university's Academic Health Center, replaces Edward W. Ciriacy, M.D., who had served as department head since 1971.

Woman Physician of the Year

Pat Cole, M.D., a family physician at Hennepin County Medical Center, was named Woman Physician of the Year by Alpha Epsilon Iota, a professional society of women physicians. The award recognizes outstanding contributions to the medical community in service or education. Cole is assistant professor of family practice at the University of Minnesota and program director for the Family Practice Residency Program.

Radiological Society Award

J. Thomas Payne, Ph.D., is the first physicist to receive the Hartman Award from the Minnesota Radiological Society. Payne is involved in all aspects of radiologic physics at Abbott Northwestern Hospital in Minneapolis. He received the award in November, the month that marks the 100th anniversary of the discovery of x-rays.

As a teacher of radiologic physics at the University of Minnesota, Payne taught more than 300 medical residents and nearly 1,000 technologists. He also became one of the primary consultants in radiologic physics to Minnesota's private radiological community.

HealthPartners Vice President

David Gregg, M.D., has joined HealthPartners as vice president and associate medical director for worksite health. In his new role, Gregg will coordinate the development of worksite care delivery initiatives, worksite-based prevention programs, and Partners for Better Health. He also will oversee workers' compensation and occupational/environmental medicine services.

In his 14-year medical career, Gregg has practiced in internal medicine and occupational health; developed and directed workers' compensation managed care programs; and served as a health systems analyst and consultant with InterStudy of Excelsior, Minnesota. He also has served as a member of the clinical faculty at the University of Minnesota Medical School, Minneapolis, and most recently he held medical directorship positions with Abbott Northwestern Hospital in Minneapolis and Allina Health System.

Honduran Medical Mission

Mayo Clinic plastic surgeons Uldis Bite, M.D., and Themis (Sam) Economou, M.D., and Mayo nurse James W. Mackey, R.N., joined 32 physicians, dentists, nurses, and assistants on a medical mission in mid-November to help children in Juticalpa, Honduras. Bite and Economou performed cleft lip and palate surgeries free of charge for about 50 to 60 Hondurans. They are volunteers for Surgical and Medical Assistance Relief Teams (S.M.A.R.T.), a nonprofit organization.

Each relief team consists of 14 to 40 volunteers who pay their own expenses and donate their time for the trip. Relief team operations are performed in often primitive conditions. "The hospitals simply do not have enough facilities or supplies," says Teresa

Searcy, S.M.A.R.T. director.

"Many times there is no electricity, antibiotics, or even sheets on the beds. We travel self-contained and bring all our own supplies. The only thing we need when we begin to operate is oxygen."

Places

.....

'U' Forming Center to Investigate Mysterious Diseases

The University of Minnesota is forming a new center to investigate outbreaks of mysterious diseases in Minnesota. The International Center of Antiviral Research and Epidemiology, or I Care, will combine the university's clinical trials, virology, and pharmacology divisions into a team that will identify, track, and treat viral diseases and emerging infections. Henry Balfour, M.D., is the head and founder of the center. He has raised \$1 million in private funding and hopes to raise an additional \$2 million to support the center.

University researchers will work closely with the Minnesota Department of Health's epidemiologists and its Emerging Infection Program. The center also has arrangements with Hennepin County Medical Center, St. Paul-Ramsey Medical Center, the universities of Nebraska and Iowa, and researchers in Europe. Research at the center will focus on illnesses caused by the herpes family of viruses.

Fairview Serves Western Suburbs

Fairview Health System will open WestRidge Medical Clinic on December 4 to serve residents of Minnetonka, Plymouth, Wayzata, and surrounding communities.

The \$1 million family medicine clinic, located in the Rasmussen Business College Plaza at 12450 Wayzata Boulevard, Minnetonka,

will provide comprehensive medical care for infants, children, and adults. Staffed by family physician Peter Boardman, M.D., the clinic will also provide surgical services.

WestRidge Medical Clinic facilities include nine exam rooms, on-site laboratory and x-ray services, and a special procedure room for minor surgeries. Additional space is available to house asthma and allergy specialists, and adjacent space is earmarked for Fairview Home Care and Hospice, a home health service scheduled to open in early 1996.

Forest Lake Clinic Plans to Expand

Forest Lake Doctors' Clinic plans to build a new facility to be located on Highway 61, just south of its current location, by next summer.

The Forest Lake Doctors' Clinic, which was established in 1960, has a medical staff of 25, including nine family practitioners, three physician assistants, an ob/gyn, a pediatrician, and a general surgeon. It will remain open to patients while the new clinic is being built.

The new one-level structure will house 44 exam rooms, three rooms for minor and surgical procedures, more facilities for diagnostic services, and an upgraded phone system that will provide more direct lines for patient calls.

The new clinic will offer more women's health services and provide diagnostic services, such as mammography and stress and ultrasound testing, which are currently unavailable. District Memorial will continue to be the main referral hospital for Forest Lake Doctors' Clinic.

The clinic is part of the Minnetonka-based Allina Health System.

Fairview Announces Name, Site for Hospital in Chisago County

The Minneapolis-based Fairview Health System has announced the name and site of the new regional medical facility it will build

northeast of the Twin Cities. The facility, to be called Fairview Lakes Regional Medical Center, will be located just south of Wyoming and 2.5 miles north of Forest Lake between Interstate 35 and Highway 61. The medical center is the product of the 1994 affiliation of Fairview with Chisago Health Services, an integrated system of hospital and physician clinics located in southern Chisago County, and District Memorial Hospital of Forest Lake.

When the new medical center opens, the inpatient hospital facilities in Chisago City and Forest Lake will close, said Scott Wordelman, senior vice president of Fairview and CEO of Chisago Health Services. The Chisago site will continue to house a clinic and long-term care facility. The new center will provide inpatient beds, diagnostic and rehabilitation services, emergency care, and offices for primary care and specialty physicians. Construction will begin in 1996.

Socioeconomics

Allina and HealthEast Join Forces

Allina Health System and HealthEast have agreed to join forces. Their plan falls short of a full merger but will tie the organizations' health care delivery systems together.

As *Minnesota Medicine* goes to press, details of the agreement have yet to be finalized. The organizations have signed a letter of intent to create a new physician organization that brings together health care delivery and financing, and a second letter of intent to develop an ambulatory health care center in the southeastern portion of the east metro area.

In addition, Allina's Medica health plan and HealthEast have signed an agreement that will enable Medica enrollees to use HealthEast doctors and hospitals for inpatient and outpatient services effective December 1. The organizations had stopped working

together three years ago after payment disputes.

The physician network for the new health care delivery system will be anchored by HealthEast's and Allina's employed physicians. The organizations plan to invite other east metro primary care and specialty physicians to round out the physician component.

With this agreement, Allina will become HealthEast's largest source of revenue, according to Tim Hanson, chief executive of HealthEast. Previously, Allina accounted for less than 5 percent of HealthEast's revenues, he said.

"In order for us to meet market needs, we've needed to configure broader choice," said John Grotting, vice president of Allina's delivery services group, in a Twin Cities *Star Tribune* article. "The world has changed so dramatically that we and HealthEast both saw that by working in a cooperative agreement here, we could deliver more appropriate and efficient care."

The Minnesota Attorney General's Office will be closely examining the arrangement, according to attorney general spokesperson Steve Kinsella.

University of Minnesota and Fairview Agree to Affiliate

The University of Minnesota and Fairview Health System have agreed in a letter of intent to integrate their health systems. The planned affiliation would create a comprehensive delivery system for primary, acute, ambulatory, tertiary, and long-term care. In 1994, the organizations merged their obstetrics and neonatal intensive care services. The groups hope to reach a final agreement on the new arrangement by January 1.

"We anticipate a very bold, sweeping reconfiguration of the university's health system," said William Brody, M.D., Ph.D., Academic Health Center provost. "This proposed affiliation would maintain and strengthen our hospital, give us access to primary

care, and allow us to be an open player in the market." He emphasized that the final arrangement will protect the University of Minnesota Medical School's academic mission.

Park Nicollet Foundation Affiliates With HealthSystem Minnesota

The HealthSystem Minnesota Board of Directors has announced it is affiliating with Park Nicollet Medical Foundation effective January 1. The foundation will assume a new name: Institute for Research and Education HealthSystem Minnesota. HealthSystem Minnesota, an integrated health care system located in St. Louis Park, already includes the Park Nicollet Clinic.

The Institute for Research and Education will retain its 30-member volunteer board of directors and will have representation on the HealthSystem Minnesota board. A. Stuart Hanson, M.D., will continue to serve as president of the institute, and James V. Toscano, M.D., will remain executive vice president.

Last year, the institute raised \$7.3 million in public support to provide health education for health care professionals and patients and to conduct clinical and health services research.

BCBSM Funding Uninsured Study

The Blue Cross and Blue Shield of Minnesota Foundation is providing funding for a survey of Minnesota's uninsured. The Institute for Health Services Research (IHSR) of the University of Minnesota's School of Public Health will conduct the study. The purpose is to measure the percentage of Minnesotans who lack health coverage and to determine if that percentage has changed since 1990, based on a previous IHSR study.

The grant covers the entire cost of the study, which is expected to be about \$200,000. Study results will be available in July 1996.

Columbia Park and Allergy Associates Merge

Columbia Park Medical Group, P.A., and Allergy Associates, P.A., both located in the northern metro area, have merged. The groups will use the name Columbia Park Medical Group.

"We are excited about this venture because we believe that Allergy Associates will help our group expand its scope of patient care," said Gary A. Van House, chief executive director of Columbia Park Medical Group.

Rates, Trends, Data

Kids Drink for the Feeling, Not Friends

Teenagers drink alcohol and use drugs because they like the feeling of being drunk or high and because it helps them forget their problems, according to a national survey conducted by Minnesota-based Hazelden Foundation.

The survey showed that parents typically think their children drink alcohol or use drugs because everybody else is doing it, but teenagers say something different. In response to the question, "Why do you think teenagers drink or use drugs?" 79 percent of teenagers said they like the feeling of being drunk or high, but only 67 percent of parents thought this was the reason. Sixty-six percent of teenagers said it's because everybody else is doing it; 87 percent of parents said they believe this is why. Forty-four percent of teenagers said it was because other kids will think they're weird if they don't, compared with 79 percent of parents.

The telephone survey included 300 parents and 250 teenagers picked at random from around the country.

Minnesota Second Healthiest State in Nation

Minnesota tied with Utah as the second healthiest state in the nation, according to the ReliaStar

State Health Rankings (formerly called the NWNL State Health Rankings). New Hampshire tops the list as the healthiest state for the second year in a row, while Mississippi has the least healthy population in the United States.

Minnesota remained among the top five states in these categories: motor vehicle deaths, high school graduation, access to prenatal care, disability status, heart disease, total mortality, and premature death. Prevalence of smoking and risk for heart disease remain high compared with other health measures.

Overall, the health of Americans has improved 3.1 percent since 1990, largely because of a decline in smoking rates, greater state support for public health care for low-income people, and lower infant mortality. Thirty-six states have healthier populations in 1995 than in 1990, with some states showing gains of 13 percent or more.

"Looking at the healthiness of state populations over the last six years, we're clearly headed in the right direction," said Dan McCormick, vice president of health marketing and development for ReliaStar. However, he pointed out that increases in violent crime and a higher rate of infectious disease are offsetting health improvements. In addition, despite falling cigarette smoking rates among adults, adolescent smoking is on the rise.

Other top-ranking states include Connecticut, Hawaii, Vermont, Massachusetts, Iowa, Wisconsin, Maine, and Nebraska. In addition to Mississippi, the bottom-ranking states include Louisiana, South Carolina, West Virginia, Arkansas, Nevada, Alaska, New Mexico, Alabama, Florida, Kentucky, New York, and Tennessee.

Gap in Primary Care Physicians' Pay Narrowing

Although the earnings of primary care physicians in managed care practices continue to exceed those

of primary care physicians in non-managed care practices, the gap is getting smaller, according to the 1995 Physicians Compensation Survey by Ernst & Young.

The survey found that primary care physicians in practices with more than 50 percent of gross revenues from managed care earned an average of \$116,600 in 1995, compared with earnings of \$137,900 in 1994. Primary care physicians in practices with less than 50 percent managed care revenues earned \$115,000 in 1995, compared with \$108,000 in 1994.

"The decrease in earnings of primary care physicians in predominantly managed care practices may be due to improved productivity and cost-containment programs," said James A. Rodeghero, Ph.D., national practice leader for physicians' compensation services in Ernst & Young's Los Angeles office.

The survey revealed similar effects of managed care on the earnings of specialists. While the average income of specialists in managed care practices remained constant or showed slight decreases, earnings of specialists in non-managed care practices increased dramatically, from \$132,000 in 1994 to \$162,000 in 1995.

Specialists still earn more than primary care physicians, including those in family medicine, internal medicine, pediatrics, and ob/gyn. The survey reports that median pay in managed care practices for medical specialists (cash only, net of benefits and retirement) is \$147,000. Median primary care physicians' earnings are \$124,300. Surgical specialists, with median annual earnings of \$174,900, continue to be the most highly compensated in all types of practice.

Law & Policy

Pharmacy Company Settles With Minnesota and Other States

Medco Containment Services, a pharmacy based in New Jersey, has

agreed that when it calls physicians to suggest switching a patient's prescription, it will tell the doctor when the suggested drug is manufactured by its parent company, Merck. Medco and Merck also agreed to pay \$1.9 million under a settlement with the Minnesota attorney general and 16 other states. Each state will receive \$115,000. Minnesota's suit was part of a series of actions taken to end questionable prescription drug advertising and promotions.

The suit said Medco called doctors to suggest less costly alternative drugs to those originally prescribed for patients, but the pharmacy didn't disclose that it was related to Merck when it suggesting switching to a Merck drug. David Woodward, an assistant Minnesota attorney general, said Medco significantly increased the sale of Merck drugs after Merck acquired the pharmacy in a 1993 merger.

Medco and Merck did not admit wrongdoing in the settlement. Kevin Colgan, a spokesman for Merck and Medco, said company pharmacists typically call doctors to suggest a switch if the prescribed drug is similar to one of 70 drugs on its formulary, mostly generics. The doctors must approve the change. Four drugs on the formulary are Merck products, although at least one is more expensive than the competitor's equivalent.

Medical Research

Better Detection Increasing Prostate Cancer Rates

The number of prostate cancer cases is on the rise, but the increase can be at least partially attributed to use of the prostate-specific antigen (PSA) test, according to an article from Mayo Clinic in the November 7 *Journal of the American Medical Association*. Steven J. Jacobsen, M.D., Ph.D., and colleagues from the Mayo Clinic studied men in Olmsted County to determine how much the prostate cancer incidence rose once PSA

testing became a standard procedure for prostate cancer screening. Comprehensive centralized medical records kept by health care providers in Olmsted County allowed researchers to examine the changes in prostate cancer incidence from 1983 (four years before PSA tests were used as a standard screening tool in that community) to 1992.

From 1983 to 1992, there were 549 Olmsted County men with a first diagnosis of prostate cancer. The age-adjusted incidence of prostate cancer increased from 64 per 100,000 person-years (one person followed for one year) in 1983 to 215 per 100,000 person-years in 1992, a 3.4-fold increase.

A similar pattern emerged in the age-specific incidence rates. Among men aged 50 to 59 years, incidence rates increased from 25 per 100,000 person-years in 1983 to 119 in 1986, followed by a greater increase to 137 in 1988 and generally increasing thereafter. Among men aged 60 to 69 years, rates increased from 187 per 100,000 person-years in 1983 to 388 in 1986, to 645 in 1988, and to 1,275 per 100,000 person-years in 1991. A similar increase occurred for men aged 70 years and older, but the incidence appeared to decline again after 1990.

"The results of this study indicate that the recent increases in the incidence of prostate cancer are, in fact, due to increased case finding that has resulted from the measurement of serum PSA levels and the raised public awareness of the disease in the community," the authors write. "Further, it appears that the increase may be transient, in that rates are beginning to decline in the oldest age groups despite continual increases in the use of serum PSA measurement." They attribute this decline to the depletion of the pool of previously undiagnosed cases of prostate cancer that occurred with the introduction of PSA. MM

We challenge you...

**You say you want a
comfortable retirement,
college education for your kids
and security for your family.**

**Be honest...
what are you really doing about it?**

Everyone says they want a comfortable retirement and anyone can sell you a product. The difference in working with MMBR is that we have systems and people, endorsed by the association, that will challenge you with the tough decisions required for success.

No wasted time or sugar coating. As part of the MMBR high value mission, Minnesota Physicians Insurance Agency counselors are experienced professionals trained to help you to prepare for the future you really want.

So, if you really want to do something about your future call MMBR and ask about our no hassle, to the point, financial reviews.

Make tomorrow happen by taking the challenge today!



Upcoming Seminars:

January 24, 6:00pm-7:30pm
Practice Succession Planning.
What happens to my practice in
the event of death or disability?

February 3, 8:30am-3:00pm
Innovative Financial Strategy
Seminar

**Space is limited. Call now to
reserve your seat.**

MPIA brings you high value
services including:

- ★ Tax favored programs to help
you build capital.
- ★ Insightful retirement, and
estate planning.
- ★ Comprehensive employee
benefit services.
- ★ Quality life insurance and
disability income coverage.

For assistance with your insur-
ance or financial needs or to
reserve a place at an upcoming
seminar, please call (800) 298-
6627.

MPIA
MINNESOTA PHYSICIANS
INSURANCE AGENCY
A MMBR company

HYSTERECTOMY

continued from page 32

Table 6

Total number of patients from November 1, 1991, to March 1, 1995: 158

Procedures	Cases
Laparoscopic hysterectomy	62
Laparoscopic hysterectomy with bilateral S & O	79
Laparoscopic hysterectomy with laparoscopic burch	17
Proposed laparoscopic hysterectomy that resulted in open procedure	6

tissue examination of the myomatous hysterectomy specimen. All three patients are being followed using the University of Minnesota Gynecologic Oncology protocol and have had no recurring cancer after three-plus years.

Discussion

When a physician advises hysterectomy, the patient should always obtain a second opinion. If the gynecologist proposes laparoscopic-assisted hysterectomy, the patient should inquire about the physician's experi-

ence with the procedure and ask how many laparoscopic-assisted hysterectomies the physician has performed. Laparoscopic-assisted hysterectomy should only be performed by those who have adequate training and experience and preferably are board-certified or board-eligible in obstetrics and gynecology. These procedures should only be performed in hospitals that have competent anesthesia departments, fully staffed and equipped operating rooms, fully staffed laboratories and blood banks, and nursing staff familiar with the

pre- and postoperative care of these patients. This does not mean, however, that this procedure cannot be performed in a rural setting as long as strict criteria for patient selection are used.

Use of the lap-

Table 7

Operating room times

Minimum operating room time	57 minutes
Maximum operating room time	252 minutes
Current average operating room time	60-70 minutes

CONTINUING MEDICAL EDUCATION

ST. PAUL-RAMSEY MEDICAL CENTER
1996 WINTER/SPRING CONFERENCE SCHEDULE

NIOSH-Approved Spirometry Training	January 18-19 April 18-19
Burn Care Today	February 22-23
Family Medicine Today	March 7-8
Occupational Medicine Update	March 22
Critical Care Update	March 28-29
ENT Update	April 12
Agricultural Medicine	April 19
Ob/Gyn Update	April 25-26
Fitting the Work to the Worker: Preplacement Evaluation, Fitness for Duty Evaluation, and Advanced Medical Case Management ...	May 15-17
Workers' Compensation	June 6-7
Infection Control in Long Term Care Facilities	TBA

INFORMATION AND REGISTRATION:

Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612/221-3992 • Fax 612/292-4773

St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of
the HealthPartners Family of Health Care Organizations

CIME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

RAMSEY

roscope significantly enhances the patient's safety: Approximately 40% of women contemplating hysterectomy have had previous abdominal surgery, so adhesions are likely, possibly involving the uterus or adnexa. Visualization and removal of adhesions may be performed laparoscopically before making the uterine excision. Additionally, by using the laparoscope, the surgeon can assess the pelvic contents to confirm the diagnosis, evaluate the extent of the problem, or detect pathology. The laparoscope also permits the surgeon to verify that there is no intra-abdominal bleeding at the completion of surgery.

Laparoscopic surgery is the wave of the future, not only because it contains costs, but more important, because it is less painful and patients can more rapidly resume full-time activity.

MM

Charles Tietz is an obstetrician/gynecologist in Virginia, Minnesota.

CROUSE

(continued from page 7)

can only do part of the job of training physicians because less is happening in hospitals, and more is happening in clinics and other ambulatory settings."

Crouse believes in balancing academic rigor with practical, clinical experience. Academic rigor includes research. Clinical experience includes community involvement. He encourages students to present health and wellness talks at senior centers and other public forums because teaching is part of a doctor's career. "We teach [medical students] that they are not just responsible for their patient's liver, but for the whole patient, as well as the family and community."

Family practice students will likely do better academically if they are trained in a community supportive of family medicine, according to Crouse. "The University of Minnesota-Duluth students are exposed to positive role models in a community with positive beliefs about family medicine," Crouse says. "Even Duluth subspecialists support family medicine. You cannot export what we have here in Duluth to a place like New York."

Providing more curriculum content in a clinic setting requires physicians and the public to change their expectations, Crouse believes. Traditionally, clinics have not been thought of as sites for education. "There's a productivity concern, and some patients may not want to be seen by a student," says Crouse. Based on Crouse's experience in Spooner, though, the latter is not a problem if the clinic experience is structured properly. "Spooner is a good role model," he says. "Students would see the patient first, while I saw two other patients. Patients liked the attention and got used to students to the point where they'd question me when I didn't have a student along."

When you ask Byron Crouse what interests him, he tells you "everything." He believes in athletic cross-training, not because it offers physiological advantages, but because it's

an excuse to play lots of games. "I find all sports challenging and interesting," he says. "I have so many interests and hobbies I'm afraid to try something new—like windsurfing—because I'm afraid I'll like it."

He developed a sports medicine curriculum for local schools during his years with the Family Practice Residency Program. He did the same in Spooner.

Crouse recently chaired the board of directors for Grandma's Marathon, which brings about 8,000 runners to Duluth each June. He's volunteered in the medical tent for years and is now the marathon's medical director. Those much appreciated massages runners now receive were partly his idea. So was the 5K William Irvin run, held in conjunction with Grandma's.

His wife, Pam, is an assistant professor of nursing at the College of St. Scholastica, where, among other things, she promotes and develops the rural nursing curriculum. They met at St. John's Hospital in St. Paul. He was an orderly. She was a nursing assistant. Their 17-year-old daughter, Andrea, is a senior at Duluth East, and 14-year-old Daniel attends Duluth's Marshall School.

Duluth is the perfect town for Crouse. UMD is the perfect school. Crouse can exercise his enthusiasm for rural family practice in a town where medicine is the largest private-sector employer and the school is nationally recognized for family medicine excellence. And he can golf, fish, and shoot pheasants. It's a town for a guy who believes in balance.

MM

Howard Bell is a free-lance writer who recently moved from Duluth, Minnesota, to Onalaska, Wisconsin.

"Commuting has been eliminated and we've gained sunshine and a more relaxed pace of life."

David J. Houghland, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a 55 year-old, multi-specialty group of 120+ physicians, has several practice opportunities throughout its practice locations. Currently, we are seeking:

WENATCHEE

- Ophthalmologist (w/surgical retina)

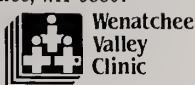
OMAK/MOSES LAKE

- Family Practice w/OB
- Orthopedist

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711
ext. 5203



Look for this seal



The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBer), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this Seal. This Seal is your assurance that the product or service offered meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the  the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR.. physicians working for physician

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES

*A physician-owned, for profit
corporation of the MMA and HMS*

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

DECEMBER 1995

Dec. 7 **Cardiology Today and Tomorrow** Mayo Foundation; satellite teleconference. CONTACT: Registrars, Mayo Foundation, Section of CME, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Dec. 7-9 **Cardiopulmonary Medicine** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

JANUARY 1996

Jan. 8-12 **Bone and Soft Tissue Tumors** Mayo Foundation; Mauna Lani Bay Hotel, Kohala Coast, Hawaii. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

FEBRUARY 1996

Feb. 2 **Duluth Clinic Sixth Annual Family Practice Conference** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Feb. 10-14 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 22-23 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 29-March 2 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1996

Mar. 7 **Annual Gentle Journey Conference: Palliative Medicine Approach to the Relief of Suffering** Twin Cities Hospices; Sheraton Inn Midway, St. Paul, MN. CONTACT:

Lee Cummins, 1450 Energy Park Drive, St. Paul, MN 55108; 612/232-2600.

Mar. 7-8 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 22 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 28-29 **Critical Care 1996** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

APRIL 1996

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 25-26 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

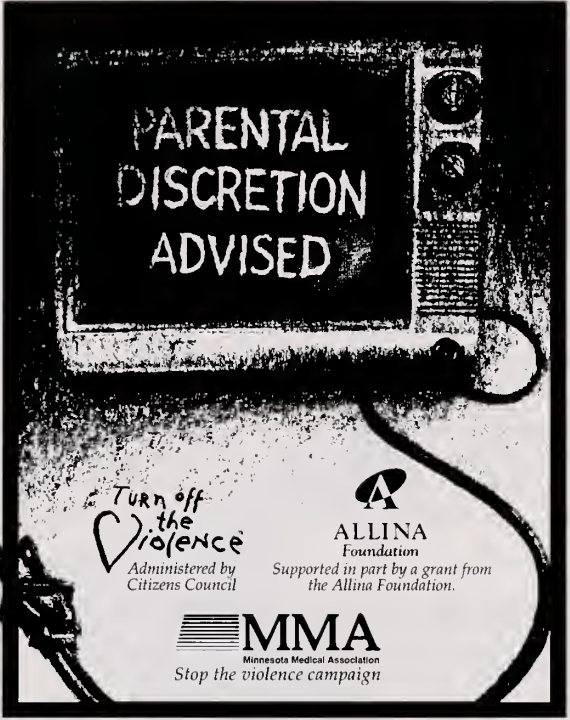
JUNE 1996

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

AUGUST 1996

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.



PARENTAL
DISCRETION
ADVISED

Turn off
the
Violence
Administered by
Citizens Council

ALLINA
Foundation
Supported in part by a grant from
the Allina Foundation.

MMA
Minnesota Medical Association
Stop the violence campaign

Stop the media violence

Media violence is a health hazard to kids. As a physician, you can help by educating patients! Provide parents with information on taking charge of the media in their children's lives by limiting viewing, providing choices, and talking about what is being shown.

For further information, or to order posters and brochures to display in your office, contact:

Minnesota Medical Association
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
612-378-1875

FAMILY PRACTICE OPPORTUNITIES HealthPartners

HealthPartners offers excellent family practice opportunities for BC/BE family practitioners. HealthPartners, a staff-model HMO, offers its physicians excellent salaries, generous benefits, a balanced lifestyle with practice scheduling flexibility, and the opportunity to practice medicine without the headaches of managing an office.

The Family Practice Department is staffed by over 75 BC/BE physicians and offers a broad range of full-range and limited-range practice options.

To inquire about specific opportunities, please call (612) 883-5337, 1-800-472-4695, or send CV to: HealthPartners, Physician Services, Attn: Lori Fake, 8100 34th Avenue South, PO Box 1309, Minneapolis, MN 55440-1309.

 **HealthPartners**

HealthPartners's mission is to improve the health of our members and our community.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., December 15 for February ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

General Surgeon, Ob/Gyn, Family Practice, Internal Medicine to join progressive physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/525-6701. (*6/95-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine, (oncology, pulmonology, and nephrology), family practice, ophthalmology, and ob/gyn. Excellent salary/benefits package includes guaranteed salary the first year with full partnership after one year; health, dental, and life insurance; pension/profit sharing; and relocation assistance. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 24-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- INTERNAL MEDICINE
- FAMILY PRACTICE
- PEDIATRICS
- ORTHOPEDIC SURGERY
- OTOLARYNGOLOGY
- UROLOGY
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Filmore Street
Alexandria, MN 56308
612-763-5123

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: family medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates nine branch offices in southeastern Minnesota and staffs affiliate hospital emergency room. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (9/95-R)

Mankato, Minnesota: FP needed to join group of three board-certified family physicians and newly added part-time nurse practitioner and physician assistant in fast-growing, full-range practice. Ob optional. Population approximately 40,000. Seventy miles to Twin Cities. Five colleges nearby. Subspecialty consultation readily available on hospital staff. Academic appointment available. Call Gregory Kutcher, M.D., or Linda Dulas, Clinic Manager, 1695 LorRay Drive, North Mankato, MN 56003; 507/387-8231. (*11/94-R)

Urgent Care BC/BE Internal Medicine

Opportunities are available for part-time or full-time work in the Urgent Care/Emergency Room. Schedule is flexible. No night, holiday, or weekend coverage is required. Inquiries and a copy of CV may be directed to:

Jonathan Cohen, M.D., MPH
Director, Urgent Care/Emergency Department (1110)
Veterans Affairs Medical Center
One Veterans Drive
Minneapolis, MN 55417
612-725-2158



An equal
opportunity
employer.

Michigan's Upper Peninsula Escanaba

St. Francis Hospital

University Affiliated
Cardiac Rehab and GI Lab
Four Surgical Suites
Member OSF Healthcare system

Escanaba, Michigan

Resort Community
Located on Lake Michigan
Private Schools Available
High Quality/Low Cost of Living

BC/BE Physicians Needed

Emergency Medicine
Internal Medicine
Orthopedic Surgery
Noninvasive Cardiology
Pediatrics

Send your CV to Marie Noeth, St. Francis, Inc., 4541 North Prospect, Suite 400, Peoria, IL 61614; Fax 209/685-2574 or call 800/438-3745.

BC/BE Ob/Gyn and ENT: The Owatonna Clinic, P.A., is seeking the right physicians to join a well-established, progressive, multispecialty group, just one hour south of the Twin Cities. Contact David Berg, Administrator, 134 Southview, Owatonna, MN 55060; 507/455-4441.

(*7/95-R)

Ski Steamboat Colorado: Three bedroom, three bath, non-smoking condo. Physician-owned. Sleeps eight. Washer/dryer, fireplace, heated garage, pool, sauna, hot tubs, cable TV, VCR, compact disc stereo. Free shuttles to lifts and town. Saturday to Saturday rentals, 612/427-8510.

*2-12/95

Internal Medicine: The Grand Forks Clinic, a 140-physician multispecialty group, is seeking an 11th internist. Clinic is a state-of-the-art facility, connected to a 350-bed acute-care hospital. Teaching and research available in affiliation with the University of North Dakota School of Medicine. Call Charles Matenaer at 800/611-2777.

*2-12/95

Birchbark Canoe Building Course: Summer 1996, Lake Superior. "Total immersion in birchbark canoe construction," Lorenzo Carcereri, M.D. (Italy). "Absolutely delightful," Lawrence Manion, M.D. (New York). Information: David Gidmark, Department V, Box 26, Maniwaki, Quebec J9E 3B3, Canada.

*2-1/96

Family Practitioner

Want to share call with 11 other family practitioners and live in the Brainerd Lakes Area? Immediate opening available at Brainerd Medical Center.

Brainerd Medical Center, P.A.

- 30-physician independent multispecialty group
- Located in a primary service area of 40,000
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital—St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Less than 2 1/2 hours from the Twin Cities, Duluth, and Fargo
- Large, very progressive school district
- Great community for families

Call Collect to Administrator:

- Curt Nielsen
218-828-7105 or
218-829-4901
2024 South 6th Street
Brainerd, MN 56401



NORTHERN EXPOSURE

Northeastern Minnesota is home to the Boundary Waters Canoe Area Wilderness and Voyageurs National Park. Its setting is not as remote as the popular television series, but you will be exposed to your share of wildlife, lakes, streams and a lot of friendly people working in a 30-physician, multi-specialty clinic — natural reasons why physicians at East Range Clinics, Ltd., enjoy a unique quality mix of career and four seasons of recreation that doesn't exist elsewhere.

East Range Clinics, Ltd. currently has openings in Family Practice, Internal Medicine, Orthopedics, and ENT. Outstanding growth potential, first-year salary guarantee and partnership options are available for qualified applicants.

Send C.V. in confidence to:

East Range Clinics LTD 

Bill Doran, Physician Recruiter

910 Sixth Avenue North, Virginia, MN 55792 1-800-377-3290 or 218-741-0150

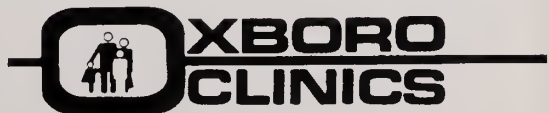
WHEN YOU WANT IT ALL...

With a commitment to excellence and a focus on the total needs of each patient. Oxboro Clinics blend a 'primary' approach with major centers of excellence in a broad range of specialty care.

Picture yourself as a physician in a large, progressive, multi-specialty practice with offices in Bloomington and Burnsville, Minnesota. Benefit from the support of a large system without relinquishing your professional autonomy.

Positions available for board-certified and board-eligible Physicians:

- OBSTETRICS/GYNECOLOGY
- INTERNAL MEDICINE • URGENT CARE



Contact: Physician Placement Office

Fairview Clinic Services

600 West 98th Street, Suite 390

Bloomington, MN 55420

(612) 885-6224 or toll free 1-800-842-6469

Clarkson Family Medicine opened its doors July 1, 1991. We have filled in the Match Program every year since then and have expanded from a 12-resident program to an 18-resident program in 1995. We have seen our graduates, as a group, score in the top 10 percent nationally on the in-training exam. We currently have four full-time family practice faculty, one obstetrician, one pediatrician, and full-time behavioral science coverage, including two part-time psychiatrists. In order to provide the training necessary to prepare our residents for rural practice, including extensive obstetrics and procedural experience, we are recruiting two additional family physician faculty. Requirements include practice and/or teaching experience, strong obstetrics background, and a desire to participate in a new, exciting, and growing residency program. Responsibilities and salary are negotiable and based on experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants who use tobacco products. EOE. Send CV and/or letter of inquiry to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, NE 68131; 402/552-2045.

3-12/95

Family Practice, Pediatrician, Occupational Medicine Physician, BC/BE to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area.

Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AA/EOE.

3-12/95

Orthopedic Surgeon—Illinois: St. Joseph Medical Center, Bloomington, a member of OSF HealthCare, is recruiting for a general orthopedic surgeon for this fast-growing college community. Bloomington/Normal, population 130,000, is experiencing tremendous growth and affluence as young families move in to take jobs with State Farm, Illinois State University, and other major employers. The physician will share call with another solo orthopedic surgeon; the position offers excellent salary and benefits package. We invite you to consider this outstanding practice opportunity by contacting Dawn Hamman, OSF HealthCare, Saint Francis, Inc., 4541 North Prospect, Peoria, IL 61614; phone 800/438-3740; fax 309/685-2574. 3-1/96

Stress Reliever Retreats: Come and enjoy Wisconsin's northwoods, fall, winter, spring, and summer. Executive private lakeshore homes available to qualified renters. Quiet, comfortable, picturesque, romantic weekends, weekly, monthly, seasonal. All sizes, price ranges; from cozy little cabins, to contemporary homes with vaulted ceilings, to luxurious log homes with warm fireplaces, and every-

MEDICAL DIRECTOR

SOUTHWEST TWIN CITIES LOCATION
ST. FRANCIS REGIONAL MEDICAL CENTER, SHAKOPEE

EXCITING OPPORTUNITY in SouthValley Health Campus development as St. Francis relocates hospital in mid-1996.

AS A KEY MEMBER of SFRMC senior management, the medical director:

- serves as an important medical liaison to medical community;
- works closely with the Quality Council and assists medical center in developing medical staff quality and outcomes programs;
- is responsible for physician recruitment program developed through strategic planning process.

SEEKING EXPERIENCED PHYSICIAN with Minnesota license for part-time position.

CONTACT: David Arthur; St. Francis Regional Medical Center; 325 West Fifth Avenue; Shakopee, Minnesota 55379-1200
Phone: 612-496-7521; Fax: 612-496-7525

Moonlight Home Care, Inc.

1007 East Franklin
Minneapolis, MN 55404
612/870-7886
(voice/TDD)



*"When You Want The Best
For Your Patients."*

- **Licensed, bonded and insured;** we are a provider for Blue Cross Blue Shield, MHP, Medicaid, and Medicare.
- **Multicultural staff** experienced in dealing with patients of diverse ethnic backgrounds.
- **Our phone is answered 24-hours a day, every day.**
- Services available include: **occupational, physical, home infusion, and speech therapy.**
- We also have **personal care attendants, home health aides, and homemakers** to assist with personal needs.
- **More than 200 RNs, LPNs, and HHAs** on staff with a wide range of specialties, including respiratory, psych, neonatal, and critical care.

thing in between. Send yourself, your friends, your clients! Call us for information: Property Management of Hayward, Inc., Hayward, Wisconsin, 800/454-4764. P.S. Interested in your own vacation home as an investment? If so, rent one from us or find your own, and we'll help you pay for it by occasionally renting it for you. Join the gold rush for northwoods property while it's still affordable. *2-1/96

Starbuck, Minnesota: Two family physicians needed to join two board-certified family physicians. Obstetrics optional. Well-equipped clinic and hospital. Minneapolis and Fargo, North Dakota, both within two-hour drive. Excellent school system. University of Minnesota-Morris 20 miles away. Beautiful lake area. Call Roxann Wellman, Administrator, Minnewaska District Hospital, PO Box 160, Starbuck, MN 56381; 612/239-2201. *2-1/96

Wisconsin, Michigan, Iowa: Major multispecialty groups and a staff-model HMO are seeking additional physicians specializing in family practice, internal medicine, pediatrics, hematology/oncology, nephrology, and occupational medicine. Innovative, growing practices in safe, progressive communities. Choose from suburban and metropolitan cities, college and resort towns, or rural destinations. Enjoy four distinct seasons and an abundance of recreation at pristine lakes and forests. For more information, call Strelcheck & Associates at 800/243-4353. *1-12/95

IT'S TIME FOR A CHANGE.

Are you spending your free time on call and not with your family and friends? Are you spending too much time on paperwork and not enough time with your patients? Then it's time for a change.

At Central Minnesota Group Health Plan you won't spend your life on call. We offer regular hours and limited on-call hours. Yet, with our in-house ancillary services, state-of-the-art equipment, full-service facilities and administrative support, you'll be able to develop a rewarding and fulfilling practice, without paperwork. So you can still have a life of your own in Minnesota's fastest growing city.

Call Central Minnesota Group Health Plan today and put time on your side.



Central Minnesota Group Health Plan

Call Stephanie Jussila, Physicians Services 1-800-284-3142
1245 15th Street North, St. Cloud, MN 56303 • (612) 253-5220
AA/EOE

URGENT CARE OPPORTUNITIES

HealthPartners, Inc.

HealthPartners, Inc., is looking for BC/BE Family Practice and Internal Medicine physicians to work in our Urgent Care Medical Centers on evenings and weekends.

The Urgent Care clinics are supported by a 24-hour After-hours Care Team that is staffed with specially trained registered nurses. The registered nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic.

The Urgent Care clinics are located in Apple Valley, Brooklyn Center, Minneapolis and St. Paul. Staffing will be based according

to specific clinic needs. Qualified physicians would receive an excellent hourly salary and paid malpractice.

To inquire, please call (612) 883-5337, 1-800-472-4695, or send CV to:
HealthPartners, Inc., Physician Services,
Attn: Lori Fake, 8100 34th Avenue South,
P.O. Box 1309, Minneapolis, MN 55440-1309.
An EO/AA Employer.



HealthPartners

HealthPartner's mission is to improve the health of our members and our community.

General Internists

CentraCare Clinic, a growing 48-physician multispecialty group based in St. Cloud, Minnesota, seeks two general internists to staff a satellite clinic in Little Falls, Minnesota. Enjoy the support of a large multispecialty group, while enjoying the benefits of smaller town living. Attractive compensation and benefits package available.

Little Falls, gateway to the Brainerd lakes area, is a picturesque community of 14,000 located 30 miles north of St. Cloud. With outstanding schools, affordable housing and peaceful neighborhoods, Little Falls is an excellent place to raise a family.

Please contact:
John Schnettler
St. Cloud Hospital
1406 Sixth Ave. N
St. Cloud, MN 56303
1-800-835-6652

CENTRACare
CLINIC

Not Just Another Recruitment Ad: Opportunities at North Memorial-owned and -affiliated clinics will give you a shot of adrenaline because we practice in a care management environment that FPs, IMs, and ob/gyns thrive on. Guide your patients through their entire care process at one of our 25 clinics in urban or semi-rural Minneapolis locations. Plus, become eligible for \$15,000 on start date. Interested BC/BE MDs call 800/275-4790, or fax CV to 612/520-1564.

1-12/95

Family Practice: The Grand Forks Clinic, a 140-physician multispecialty group, is seeking an additional family physician at its main clinic and at one of its nearby branch offices. Teaching and/or research are readily available at the University of North Dakota Medical School with family practice residents and medical students. Call Charles Matenaer at 800/611-2777, or fax CV to 414/784-0727.

*2-12/95

DECEMBER 1995 INDEX TO ADVERTISERS

Alexandria Clinic, P.A.	58
Aspen Medical Group.....	20
Brainerd Medical Center	42, 59
Central Minnesota Group Health Plan	61
C.F. Anderson Co., Inc.	46
Chisago Health Services.....	62
Columbia Park Medical Group	42
Digital Dictation Systems, Inc.	20
East Range Clinics	59
Emergency Practice Associates	46
Fairview Clinic Services	3
HealthEast Bethesda	Cover 4
HealthEast Capitol Medical Laboratory	25
HealthPartners	42, 56, 61
Minnesota Medical Business Resources	14, 41
Minnesota Physicians Insurance Agency	51, 54
Moonlight Home Health Care	60
Multicare Associates of the Twin Cities	30
Norwest Center	30
Oxboro Clinics	59
St. Cloud Hospital	62
St. Francis, Inc.	58
St. Francis Regional Medical Center-Shakopee.	60
St. Paul Eye Clinic	45
St. Paul-Ramsey CME	52
Sauk Prairie Memorial Hospital	46
Sletto & Associates	30
THC Minneapolis	16
Veterans Affairs Medical Center-Minneapolis	58
Webb Financial Group	Cover 2
Wenatchee Valley Clinic	53
Whitesell Medical Locums, Ltd.	25

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 22 member medical staff has openings in the areas of:

Family Medicine	OB/GYN
Internal Medicine	Otolaryngology
General Surgery	Physiatry

CHISAGO HEALTH SERVICES

A subsidiary of Fairview



Please contact:
Physician Placement Dept.
Fairview Clinic Services
600 West 98th Street, Suite 390
Bloomington, MN 55420
1-800-842-6469
E-mail: fvrecruit @ aol.com

Volume 78 Index, January-December 1995

A

- Allen T: Serious Business, October, 6.
 Apple GJ: Who Bears the Risk When Physicians Are Also Insurers? May, 23.
 Attitude Adjustment: A Complacent Public Tunes Out the AIDS Epidemic. Miriam K. Feldman, November, 10.

B

- Babies on the Verge of Having Babies. David Wallinga, June, 20.
 Baumgarten A: Doling Out Risk: How Capitation Measures up in Minnesota, May, 10.
 Bearing the Bad News. Katie M. Colón, February, 10.
 Beating the Odds. Stephen Rapatz-Harr, July, 8.
 Bell H: May the Balance Be With You, December, 6.
 Bell H: Out of the Classroom—Into the Exam Room, December, 10.
 Bell H: Showcasing Primary Care, October, 8.
 Benzie DP, Frericks SB: University of Minnesota Community Rotations Expose Students to Family Practice, December, 17.
 Blum RW, Beuhring T: Guidelines for Adolescent Preventive Services: Addressing Youths' Risky Behaviors, June, 29.
 Blumer BJ: Lessons from the Butcher Case, February, 43.
 Board of Medical Practice Improves Its Complaint Handling System (The). Kent G. Harbison, January, 43.
 Bohen J: Fostering Collaborative Care, July, 6.
 Braus P: Kinder, Gentler, and Lower-Paid Women Physicians, September, 8.

BOOK REVIEWS

- Death, Science, and God: A Review of Three Books. Review of "The Troubled Dream of Life: Living with Mortality," by Daniel Callahan, "Dreams of a Final Theory," by Steven Weinberg, and "The Astonishing Hypothesis: The Scientific Search for the Soul," by Francis Crick. Charles R. Meyer, February, 48.
 Dream Fulfilled (A). Review of "As Long as Life: The Memoirs of a Frontier Woman Doctor," by Mary Canaga Rowland. Barbara P. Yawn, September, 49.
 Handler S: History's Answers to Medicine's Troubled Present. Review of "Vandals at the Gates of Medicine," by Miguel A. Faria Jr., M.D., May, 43.
 History's Answers to Medicine's Troubled Present. Review of "Vandals at the Gates of Medicine," by Miguel Faria Jr., M.D. Seymour Handler, May, 43.
 Light in the Heart of Darkness. Review of "My Own Country," by Abraham Verghese, M.D. Charles R. Meyer, November, 8.
 Meyer CR: Death, Science, and God: A Review of Three Books. Review of "The Troubled Dream of Life: Living with Mortality," by Daniel Callahan, "Dreams of a Final Theory," by Steven Weinberg, and "The Astonishing Hypothesis: The Scientific Search for the Soul," by Francis Crick, February, 48.
 Meyer CR: Light in the Heart of Darkness. Review of "My Own Country," by Abraham Verghese, M.D., November, 8.
 Meyer CR: Spreading the Fear of Infectious Disease. Review of "The Hot Zone" by Richard Preston, and "The Coming

- Plague," by Laurie Garrett, July, 45.
 Quiet Crisis (A). Review of "America's Children: Triumph or Tragedy," by Charles N. Oberg, M.D., M.P.H., Nicholas A. Bryant, and Marilyn L. Bach, Ph.D. Patsy Stinchfield, June, 42.
 Spreading the Fear of Infectious Disease. Review of "The Hot Zone," by Richard Preston, and "The Coming Plague," by Laurie Garrett. Charles R. Meyer, July, 45.
 Stinchfield P: A Quiet Crisis. Review of "America's Children: Triumph or Tragedy," by Charles N. Oberg, M.D., M.P.H., Nicholas A. Bryant, and Marilyn L. Bach, Ph.D., June, 42.
 Yawn BP: A Dream Fulfilled. Review of "As Long as Life: The Memoirs of a Frontier Woman Doctor," by Mary Canaga Rowland, September, 49.

C

- Cancer Pain Management in the Hospice Setting. John C. Manion, February, 25.
 Capitation Without Trepidation. David E. Pautz, May, 8.
 Carlson R: Tuned-in to Telemedicine, March, 10.
 Cass RM: Final Bloom, February, 8.
 Celiac Sprue in an Asymptomatic Elderly Man. Nic R. Cordum, Brendan M. McGuire, and Douglas Nelson, May, 29.
 Cervical Radiculopathy: Causes and Surgical Treatment. Michael D. Smith, April, 28.
 Chapin-Strike S: One for the Money: The Financial Benefits of EDI, October, 52.
 Chapin-Strike S: Three to Get Ready: Taking EDI from Theory to Reality, December, 43.
 Chapin-Strike S: Two for the Show: EDI and Electronic Commerce, November, 59.
 Clary BG: Physician Collective Bargaining: Antitrust Prospects and Pitfalls, August, 41.
 Clement D: Kids Shooting Kids: A Surgeon's Response, June, 8.
 Collins A, Baumgartner D, Henry K: U.S. Prisoners' Access to Experimental HIV Therapies, November, 45.
 Colón K: Bearing the Bad News, February, 10.
 Colón K: Measure of Independence (A), July, 10.
 Colón K: More than Medicine: Caring for the AIDS Patient, November, 6.
 Communities Take Aim to Snuff Out Smoking. Miriam K. Feldman, April, 10.
 Cordum NR, McGuire BM, Nelson D: Celiac Sprue in an Asymptomatic Elderly Man, May, 29.
 Critical Care for the Health System. Fran Miller Toubin, January, 6.
 Crouse BJ: Recruitment and Retention of Family Physicians, October, 29.

CLINICAL & HEALTH AFFAIRS

- Cancer Pain Management in the Hospice Setting. John C. Manion, February, 25.
 Celiac Sprue in an Asymptomatic Elderly Man. Nic R. Cordum, Brendan M. McGuire, and Douglas Nelson, May, 29.
 Cervical Radiculopathy: Causes and Surgical Treatment. Michael D. Smith, April, 28.

- Collins A, Baumgartner D, Henry K: U.S. Prisoners' Access to Experimental HIV Therapies, November, 45.
- Cordum NR, McGuire BM, Nelson D: Celiac Sprue in an Asymptomatic Elderly Man, May, 29.
- Crouse BJ: Recruitment and Retention of Family Physicians, October, 29.
- Dementia and Alzheimer's Disease: Indications, Diagnosis, and Treatment. Richard Golden, January, 25.
- Directions in HIV/AIDS Research: A Minnesota Perspective. Keith Henry, Holly Melroe, and Ray Nelson, November, 26.
- Elliott B, Renier C, Vecchi L, Clark TC: Health Care for the Uninsured in Duluth, March, 25.
- Fernandes ET, Gleich P, Ercole C: Lasers in Urology, July 23.
- Forecasting Physician Workforce Requirements in Minnesota. Reinhard Priester and Thomas E. Elliott, October, 21.
- Golden R: Dementia and Alzheimer's Disease: Indications, Diagnosis, and Treatment, January, 25.
- Health Care for the Uninsured in Duluth. Barbara Elliott, Colleen Renier, Laura Vecchi, and Terrence C. Clark, March, 25.
- Henry K, Campbell S: Needlestick/Sharps Injuries and HIV Exposure Among Health Care Workers: National Estimates Based on a Survey of U.S. Hospitals, November, 41.
- Henry K: HIV: An Endemic Health Problem in Minnesota, November, 15.
- Henry K: Management of HIV Infection: A 1995-96 Overview for the Clinician, November, 17.
- Henry K, Melroe H, Nelson R: Directions in HIV/AIDS Research: A Minnesota Perspective, November, 26.
- HIV: An Endemic Health Problem in Minnesota. Keith Henry, November, 15.
- HIV Infection in Women and Children. Kay E. Schwebke and Laura G. Hoyt, November, 35.
- Immunization Compliance Outside the Health Plans: A Non-HMO Report Card. Barbara P. Yawn, Margary Kurland, Ryan Bolton, and Allison R. Martin, August, 25.
- Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota (The). Gary Riestenberg and Douglas D. Brunette, September, 29.
- Kane J, Morken J, Boulger J, Crouse B, Bergeron D: Rural Minnesota Family Physicians' Attitudes Toward Telemedicine, March, 19.
- Laparoscopic-assisted Hysterectomy in a Rural Minnesota Hospital. Charles A. Tietz, December, 31.
- Lasers in Urology. Eduardo T. Fernandes, Paul Gleich, and Cesar Ercole, July, 23.
- Lee J, Lenzmeier T, Boulger J, Buck S, Bergeron D, Hill TJ: Retirement of Senior Physicians in Rural Minnesota: Factors Influencing Physicians' Plans to Retire, December, 21.
- Life After Medical Practice: A Retirement Profile of Minnesota Physicians. Harold C. Seim and James E. Mitchell, December, 27.
- Management of HIV Infection: A 1995-96 Overview for the Clinician. Keith Henry, November, 17.
- Manion JC: Cancer Pain Management in the Hospice Setting, February, 25.
- Manolis DC: The Perils of Prozac, January, 19.
- Needlestick/Sharps Injuries and HIV Exposure Among Health Care Workers: National Estimates Based on a Survey of U.S. Hospitals. Keith Henry and Scott Campbell, November, 41.
- Perils of Prozac (The). Deane C. Manolis, January, 19.
- Priester R, Elliott TE: Forecasting Physician Workforce Requirements in Minnesota, October, 21.
- Recruitment and Retention of Family Physicians. Byron J. Crouse, October, 29.
- Retirement of Senior Physicians in Rural Minnesota: Factors Influencing Physicians' Plans to Retire. Julia Lee, Thomas Lenzmeier, James Boulger, Sally Buck, Dale Bergeron, and Terence J. Hill, December, 21.
- Riestenberg G, Brunette DD: The Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota, September, 29.
- Rural Minnesota Family Physicians' Attitudes Toward Telemedicine. Jon Kane, Jeff Morken, Jim Boulger, Byron Crouse, and Dale Bergeron, March, 19.
- Schwebke KE, Hoyt LG: HIV Infection in Women and Children, November, 35.
- Seim HC, Mitchell JE: Life After Medical Practice: A Retirement Profile of Minnesota Physicians, December, 27.
- Should a Geriatric Nurse Practitioner Become Part of a Multispecialty Group? Barbara P. Yawn and G. Richard Geier Jr., July, 17.
- Smith MD: Cervical Radiculopathy: Causes and Surgical Treatment, April, 28.
- Tietz CA: Laparoscopic-assisted Hysterectomy in a Rural Minnesota Hospital, December, 31.
- U.S. Prisoners' Access to Experimental HIV Therapies. Abigail Collins, Dana Baumgartner, and Keith Henry, November, 45.
- Yawn BP, Geier GR Jr.: Should a Geriatric Nurse Practitioner Become Part of a Multispecialty Group? July, 17.
- Yawn BP, Kurland M, Bolton R, Martin AR: Immunization Compliance Outside the Health Plans: A Non-HMO Report Card, August, 25.

D

- Data Privacy Under MinnesotaCare. Mary Prentnieks and Shirley Qual, October, 47.
- Death, Science, and God. Charles R. Meyer, February, 48.
- Dementia and Alzheimer's Disease: Indications, Diagnosis, and Treatment. Richard Golden, January, 25.
- Directions in HIV/AIDS Research: A Minnesota Perspective. Keith Henry, Holly Melroe, and Ray Nelson, November, 26.
- Doctor Is 'In' When It Comes to Adolescents (The). Miriam K. Feldman, June, 6.
- Doling Out Risk: How Capitation Measures up in Minnesota. Allan Baumgarten, May, 10.
- Dream Fulfilled (A). Barbara P. Yawn, September, 49.

E

- Economic and Human Costs of Smoking in Minnesota (The). Dick Welch, Kathy Daly, and Judith Hilton, April, 19.
- Elliott B, Renier C, Vecchi L, Clark TC: Health Care for the Uninsured in Duluth, March, 25.
- Emerging Infectious Diseases: Controversies, Causes, and Control. Kristine L. MacDonald and Michael T. Osterholm, July, 41.
- End-of-Life Care in Minnesota. Steven Miles and Eileen Weber, February, 15.

EDITORIALS

- Capitation Without Trepidation. David E. Pautz, May, 8.
- End-of-Life Care in Minnesota. Steven Miles and Eileen Weber, February, 15.

- Freedom of Choice in Health Care Today: Myth or Reality?
Monica Wietgreffe, October, 43.
- Improvements in Diabetes Treatment. Bruce R. Zimmerman,
April, 46.
- Kiscaden S: MinnesotaCare: Round 4, January, 16.
- Miles S, Weber E: End-of-Life Care in Minnesota, February,
15.
- MinnesotaCare: Round 4. Sen. Sheila Kiscaden, January, 16.
- Pautz DE: Capitation Without Trepidation, May, 8.
- TV Violence. David Walsh, June, 14.
- Walsh D: TV Violence, June, 14.
- Wietgreffe M: Freedom of Choice in Health Care Today:
Myth or Reality? October, 43.
- Zimmerman BR: Improvements in Diabetes Treatment,
April, 46.

EDITOR'S NOTEBOOKS

- Meyer, Charles R.:*
AIDS: Public Perceptions Obscure Medical Discourse,
November, 5.
- Applying the Healing Arts to Health System Reform,
January, 5.
- Division of Labor, July, 5.
- Easing the Growing Pains, June, 5.
- Infernal Habit (An), April, 5.
- Learning by Example, December, 5.
- Mayo Mythology (The), September, 5.
- Mindful of Capitation's Risks, May, 5.
- Telemedicine Beckons, March, 5.
- Tension Is Palpable (The), October, 5.
- When Medicine Can't Cure, February, 5.
- Winning Formula (A): New Model Expands Pharmacists'
Role, August, 5.

F

- Farley H: The Surprise Visit, December, 8.
- Feldman MK: Attitude Adjustment: A Complacent Public
Tunes Out the AIDS Epidemic, November, 10.
- Feldman MK: Communities Take Aim to Snuff Out
Smoking, April, 10.
- Feldman MK: Doctor Is 'In' When It Comes to Adolescents
(The), June, 6.
- Feldman MK: Prescription for Change, August, 10.
- Fernandes ET, Gleich P, Ercole C: Lasers in Urology, July
23.
- Final Bloom. Roger M. Cass, February, 8.
- Forecasting Physician Workforce Requirements in Minne-
sota. Reinhard Priester and Thomas E. Elliott, 21.
- Fostering Collaborative Care. James Bohen, July, 6.
- Freedom of Choice in Health Care Today: Myth or Reality?
Monica Wietgreffe, October, 43.

FACE TO FACE

- Crimmins, Timothy J.:*
Critical Care for the Health System. Fran Miller Toubin,
January, 6.
- Crouse, Byron:*
May the Balance Be With You. Howard Bell, December, 6.
- Durenberger, Dave:*
Higher Office to Higher Learning. May, 6.
- Fotland, Jay:*
Fostering Collaborative Care. James Bohen, July, 6.
- Franz, Walt:*
Mayo Doc Inspires Multi-Cultural Care. Rebecca C.
Gonzalez-Campoy, March, 6.

- Gervais, Karen Grandstrand:*
The Life of a Bioethicist. Margaret Rog, February, 6.
- Mulder, Richard:*
The House Physician. Fran Miller Toubin, April, 6.
- Murray, Michael:*
Taking the Helm in Turbulent Times. J.P. Miller, Septem-
ber, 6.
- Remafedi, Gary:*
The Doctor Is 'In' When It Comes to Adolescents. Miriam
K. Feldman, June, 6.
- Schut, Ron, and Simpson, Margaret:*
More than Medicine: Caring for the AIDS Patient. Katie
Colón, November, 6 (see Simpson).
- Schwartz, Burton:*
Serious Business. Thomas Allen, October, 6.
- Simpson, Margaret, and Schut, Ron:*
More than Medicine: Caring for the AIDS Patient. Katie
Colón, November, 6.
- St. Peter, Wendy:*
Indispensable. William Hoffman, August, 6.

G

- Geber G: Health Status of Suburban Hennepin County
Adolescents, June, 24.
- Golden R: Dementia and Alzheimer's Disease: Indications,
Diagnosis, and Treatment, January, 25.
- Gonzalez-Campoy RC: Mayo Doc Inspires Multi-Cultural
Care, March, 6.
- Guidelines for Adolescent Preventive Services: Addressing
Youths' Risky Behaviors. Robert W. Blum and Trish
Beuhring, June, 29.

H

- Hamilton S: Talking to Your Patients About Gun Violence
and Gun Safety, September, 20.
- Handler S: History's Answers to Medicine's Troubled
Present, May, 43.
- Harbison KG: The Board of Medical Practice Improves Its
Complaint Handling System, January, 43.
- Haugen PS: Recollection, January, 8.
- Health Care for the Uninsured in Duluth. Barbara Elliott,
Colleen Renier, Laura Vecchi, and Terrence C. Clark,
March, 25.
- Health Status of Suburban Hennepin County Adolescents.
Gayle Geber, June, 24.
- Henry K, Campbell S: Needlestick/Sharps Injuries and HIV
Exposure Among Health Care Workers: National Esti-
mates Based on a Survey of U.S. Hospitals, November, 41.
- Henry K: HIV: An Endemic Health Problem in Minnesota,
November, 15.
- Henry K: Management of HIV Infection: A 1995-96
Overview for the Clinician, November, 17.
- Henry K, Melroe H, Nelson R: Directions in HIV/AIDS
Research: A Minnesota Perspective, November, 26.
- Higher Office to Higher Learning. May, 6.
- History's Answers to Medicine's Troubled Present. Seymour
Handler, May, 43.
- HIV: An Endemic Health Problem in Minnesota. Keith
Henry, November, 15.
- HIV Infection in Women and Children. Kay E. Schwebke
and Laura G. Hoyt, November, 35.
- Hoffman W: Indispensable, August, 6.
- House Physician (The). Fran Miller Toubin, April, 6.
- Humphrey HH III: Industry Under Fire: Minnesota v. the
Tobacco Industry, April, 23.

HEALTH REFORM SERIES

- Silversmith J: Universal Coverage: Policy Options and the Minnesota Experience. March, 42.
 Universal Coverage: Policy Options and the Minnesota Experience. Janet Silversmith, March, 42.

I

- Immunization Compliance Outside the Health Plans: A Non-HMO Report Card. Barbara P. Yawn, Margary Kurland, Ryan Boloton, and Allison R. Martin, August, 25.
 Immunizing the Adult Immigrant Patient: What to Do When There Are No Records. Gregory A. Poland, August, 18.
 Improvements in Diabetes Treatment. Bruce R. Zimmerman, April, 46.
 Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota (The). Gary Riestenberg and Douglas D. Brunette, September, 29.
 Indispensable. William Hoffman, August, 6.
 Industry Under Fire: Minnesota v. the Tobacco Industry. Hubert H. Humphrey III, April, 23.
 Investing in the Future. J.P. Miller, September, 10.
 Is Capitation Right for Your Practice? Randall S. Vollertsen and Robert B. Cumming, May, 16.

K

- Kane J, Morken J, Boulger J, Crouse B, Bergeron D: Rural Minnesota Family Physicians' Attitudes Toward Telemedicine, March, 19.
 Kids Shooting Kids: A Surgeon's Response. Douglas Clement, June, 8.
 Kinder, Gentler, and Lower-Paid Women Physicians. Patricia Braus, September, 8.
 Kiscaden S: MinnesotaCare: Round 4, January, 16.

L

- Laparoscopic-assisted Hysterectomy in a Rural Minnesota Hospital. Charles A. Tietz, December, 31.
 Lasers in Urology. Eduardo T. Fernandes, Paul Gleich, and Cesar Ercole, July, 23.
 Lee J, Lenzmeier T, Boulger J, Buck S, Bergeron D, Hill TJ: Retirement of Senior Physicians in Rural Minnesota: Factors Influencing Physicians' Plans to Retire, December, 21.
 Lessons from the Butcher Case. Barbara J. Blumer, February, 43.
 Life After Medical Practice: A Retirement Profile of Minnesota Physicians. Harold C. Seim and James E. Mitchell, December, 27.
 Life of a Bioethicist (The). Margaret Rog, February, 6.
 Light in the Heart of Darkness. Charles R. Meyer, November, 8.
 Lost to Follow-up: A Detective Story. P. Michael Nordberg, March, 8.

LETTERS TO THE EDITOR

- Caduceus Has Modern-Day Relevance (The). Jerome J. Scherek, January, 48.
 Child Abuse Article Missed Important Resource. Kathryn C. Halverson, January, 2.
 Dr. Manolis Responds to "Is Prozac Really Perilous." Deane C. Manolis, March, 3.
 Halverson KC: Child Abuse Article Missed Important Resource, January, 2.
 Hospitals Can Take Steps to Ease End-of-Life Decision Making. Scott M. Jensen, January, 3.

- Is Prozac Really Perilous? David A. Lang, March, 2.
 Jensen SM: Hospitals Can Take Steps to Ease End-of-Life Decision Making, January, 3.
 Kishel GF: Single-Payer System Would Allow More Family Time, January, 2.
 Lang DA: Is Prozac Really Perilous? March, 2.
 Let's Not Forget Outside Resources for Alzheimer's. Ronald C. Petersen, March, 2.
 Manolis DC: Dr. Manolis Responds to: "Is Prozac Really Perilous," March, 3.
 Petersen RC: Let's Not Forget Outside Resources for Alzheimer's, March, 2.
 Scherek JJ: The Caduceus Has Modern-Day Relevance, January, 48.
 Single-Payer System Would Allow More Family Time. G.F. Kishel, January, 2.
 Sturgeon R, Mosser G: Thanks PPAC Volunteers! January, 2.
 Thanks PPAC Volunteers! Richard Sturgeon and Gordon Mosser, January, 2.

M

- MacDonald KL, Osterholm MT: Emerging Infectious Diseases: Controversies, Causes, and Control, July, 41.
 Management of HIV Infection: A 1995-96 Overview for the Clinician. Keith Henry, November, 17.
 Manion JC: Cancer Pain Management in the Hospice Setting, February, 25.
 Manolis DC: The Perils of Prozac, January, 19.
 May the Balance Be With You. Howard Bell, December, 6.
 Mayo Doc Inspires Multi-Cultural Care. Rebecca C. Gonzalez-Campoy, March, 6.
 McCarthy MP: Small-Town Raceway, August, 8.
 Measure of Independence (A). Katie Colón, July, 10.
 Medical Futility Debate Continues (The). Margo S. Struthers, and Brad C. Olson, February, 29.
 Meyer CR: Death, Science, and God: A Review of Three Books, February, 48.
 Meyer CR: Light in the Heart of Darkness, November, 8.
 Meyer CR: Spreading the Fear of Infectious Disease, July, 45.
 Miles S, Weber E: End-of-Life Care in Minnesota, February, 15.
 Miller JP: Investing in the Future, September, 10.
 Miller JP: Taking the Helm in Turbulent Times, September, 6.
 Mills H: Safe Hunting, September, 25.
 MinnesotaCare: Round 4. Sen. Sheila Kiscaden, January, 16.
 MMA Introduces the Minnesota Health Care Quality and Coverage Act. Dave Renner, January, 10.
 More than Medicine: Caring for the AIDS Patient. Katie Colón, November, 6.

MEDIA WATCH

- Enough to Raise One's Blood Pressure. Charles R. Meyer, May, 2.
 Meyer CR: Enough to Raise One's Blood Pressure, May, 2.
 Meyer CR: When the Numbers Don't Add Up, December, 2.
 When the Numbers Don't Add Up. Charles R. Meyer, December, 2.

MEDICINE LAW & POLICY

- Apple GJ: Who Bears the Risk When Physicians Are Also Insurers? May, 23.
 Blumer BJ: Lessons from the Butcher Case, February, 43.
 Board of Medical Practice Improves Its Complaint Handling

- System (The). Kent G. Harbison, January, 43.
 Clary BG: Physician Collective Bargaining: Antitrust Prospects and Pitfalls, August, 41.
 Data Privacy Under MinnesotaCare. Mary Prentnieks and Shirley Qual, October, 47.
 Harbison KG: The Board of Medical Practice Improves Its Complaint Handling System, January, 43.
 Humphrey HH III: Industry Under Fire: Minnesota v. the Tobacco Industry, April, 23.
 Industry Under Fire: Minnesota v. the Tobacco Industry. Hubert H. Humphrey III, April, 23.
 Lessons from the Butcher Case. Barbara J. Blumer, February, 43.
 Medical Futility Debate Continues (The). Margo S. Struthers and Brad C. Olson, February, 29.
 Physician Collective Bargaining: Antitrust Prospects and Pitfalls. Bradley G. Clary, August, 41.
 Physician Employment Agreements: What to Look For. James Platt, July, 29.
 Platt J: Physician Employment Agreements: What to Look For, July, 29.
 Prentnieks M, Qual S: Data Privacy Under MinnesotaCare, October, 47.
 Reporting Obligations Under the Vulnerable Adults Act. Sheva J. Sanders, September, 43.
 Sanders SJ: Reporting Obligations Under the Vulnerable Adults Act, September, 43.
 Struthers MS, Olson BC: The Medical Futility Debate Continues, February, 29.
 Who Bears the Risk When Physicians Are Also Insurers? Gordon J. Apple, May, 23.

MINNESOTA MEDICAL ASSOCIATION

- MMA Introduces the Minnesota Health Care Quality and Coverage Act. Dave Renner, January, 10.
 Renner D: MMA Introduces the Minnesota Health Care Quality and Coverage Act, January, 10.
 Silversmith J: Universal Coverage: Policy Options and the Minnesota Experience, March, 42.
 Stop the Media Violence. Mark S. Vukelich, June, 16.
 Universal Coverage: Policy Options and the Minnesota Experience. Janet Silversmith, March, 42.
 Vukelich MS: Stop the Media Violence, June, 16.

N

- Needlestick/Sharps Injuries and HIV Exposure Among Health Care Workers: National Estimates Based on a Survey of U.S. Hospitals. Keith Henry and Scott Campbell, November, 41.
 Nordberg PM: Lost to Follow-up: A Detective Story, March, 8.
 Nordin J: Varicella Vaccine Recommendations, August, 21.

O

- One for the Money: The Financial Benefits of EDI. Sue Chapin-Strike, October, 52.
 Out of the Classroom—Into the Exam Room. Howard Bell, December, 10.
 Overcoming Physician Barriers to Hospice Care. Wayne H. Thalhuber, February, 18.

P

- Pautz DE: Capitation Without Trepidation, May, 8.
 Perils of Prozac (The). Deane C. Manolis, January, 19.
 Physician Collective Bargaining: Antitrust Prospects and Pitfalls. Bradley G. Clary, August, 41.

- Physician Employment Agreements: What to Look For. James Platt, July, 29.
 Platt J: Physician Employment Agreements: What to Look For, July, 29.
 Poland GA: Immunizing the Adult Immigrant Patient: What to Do When There Are No Records, August, 18.
 Prentnieks M, Qual S: Data Privacy Under MinnesotaCare, October, 47.
 Prescription for Change. Miriam K. Feldman, August, 10.
 Priester R, Elliott TE: Forecasting Physician Workforce Requirements in Minnesota, October, 21.

PERSPECTIVES

- Babies on the Verge of Having Babies. David Wallinga, June, 20.
 Beating the Odds. Stephen Rapatz-Harr, July, 8.
 Braus P: Kinder, Gentler, and Lower-Paid Women Physicians, September, 8.
 Cass RM: Final Bloom, February, 8.
 Farley H: The Surprise Visit, December, 8.
 Final Bloom. Roger M. Cass, February, 8.
 Haugen PS: Recollection, January, 8.
 Kinder, Gentler, and Lower-Paid Women Physicians. Patricia Braus, September, 8.
 Lost to Follow-up: A Detective Story. P. Michael Nordberg, March, 8.
 McCarthy MP: Small-Town Raceway, August, 8.
 Nordberg PM: Lost to Follow-up: A Detective Story, March, 8.
 Rapatz-Harr S: Beating the Odds, July, 8.
 Recollection. Phebe Saunders Haugen, January, 8.
 Small-Town Raceway. Michael P. McCarthy, August, 8.
 Surprise Visit (The). Harrison Farley, December, 8.
 Wallinga D: Babies on the Verge of Having Babies, June, 20.

PUBLIC HEALTH REPORTS

- Blum RW, Beuhring T: Guidelines for Adolescent Preventive Services: Addressing Youths' Risky Behaviors, June, 29.
 Economic and Human Costs of Smoking in Minnesota (The). Dick Welch, Kathy Daly, and Judith Hilton, April, 19.
 Geber G: Health Status of Suburban Hennepin County Adolescents, June, 24.
 Guidelines for Adolescent Preventive Services: Addressing Youths' Risky Behaviors. Robert W. Blum and Trish Beuhring, June, 29.
 Hamilton S: Talking to Your Patients About Gun Violence and Gun Safety, September, 20.
 Health Status of Suburban Hennepin County Adolescents. Gayle Geber, June, 24.
 Immunizing the Adult Immigrant Patient: What to Do When There Are No Records. Gregory A. Poland, August, 18.
 Mills H: Safe Hunting, September, 25.
 Nordin J: Varicella Vaccine Recommendations, August, 21.
 Poland GA: Immunizing the Adult Immigrant Patient: What to Do When There Are No Records, August, 18.
 Safe Hunting. Harris Mills, September, 25.
 Talking to Your Patients About Gun Violence and Gun Safety. Shari Hamilton, September, 20.
 Varicella Vaccine Recommendations. James Nordin, August, 21.
 Welch D, Daly K, Hilton J: The Economic and Human Costs of Smoking in Minnesota, April, 19.

Q

- Quiet Crisis (A). Patsy Stinchfield, June, 42.

R

- Rapatz-Harr S: Beating the Odds, July, 8.
 Recollection. Phebe Saunders Haugen, January, 8.
 Recruitment and Retention of Family Physicians. Byron J. Crouse, October, 29.
 Reed M: Shifting Balance of Power, October, 15.
 Renner D: MMA Introduces the Minnesota Health Care Quality and Coverage Act, January, 10.
 Reporting Obligations Under the Vulnerable Adults Act. Sheva J. Sanders, September, 43.
 Retirement of Senior Physicians in Rural Minnesota: Factors Influencing Physicians' Plans to Retire. Julia Lee, Thomas Lenzmeier, James Boulger, Sally Buck, Dale Bergeron, and Terence J. Hill, December, 21.
 Riestenberg G, Brunette DD: The Incidence and Prevalence of Nonfatal Gunshot Wounds in Minnesota, September, 29.
 Rog M: The Life of a Bioethicist, February, 6.
 Rural Minnesota Family Physicians' Attitudes Toward Telemedicine. Jon Kane, Jeff Morken, Jim Boulger, Byron Crouse, and Dale Bergeron, March, 19.

S

- Safe Hunting. Harris Mills, September, 25.
 Sanders SJ: Reporting Obligations Under the Vulnerable Adults Act, September, 43.
 Schwabke KE, Hoyt LG: HIV Infection in Women and Children, November, 35.
 Seim HC, Mitchell JE: Life After Medical Practice: A Retirement Profile of Minnesota Physicians, December, 27.
 Serious Business. Thomas Allen, October, 6.
 Shifting Balance of Power. Maureen Reed, October, 15.
 Should a Geriatric Nurse Practitioner Become Part of a Multispecialty Group? Barbara P. Yawn and G. Richard Geier Jr., July, 17.
 Showcasing Primary Care. Howard Bell, October, 8.
 Silversmith J: Universal Coverage: Policy Options and the Minnesota Experience. March, 42.
 Small-Town Raceway. Michael P. McCarthy, August, 8.
 Smith MD: Cervical Radiculopathy: Causes and Surgical Treatment, April, 28.
 Spreading the Fear of Infectious Disease. Charles R. Meyer, July, 45.
 Stinchfield P: A Quiet Crisis, June, 42.
 Stop the Media Violence. Mark S. Vukelich, June, 16.
 Struthers MS, Olson BC: The Medical Futility Debate Continues, February, 29.
 Surprise Visit (The). Harrison Farley, December, 8.

SPECIAL REPORTS

- Chapin-Strike S: One for the Money: The Financial Benefits of EDI, October, 52.
 Chapin-Strike S: Three to Get Ready: Taking EDI from Theory to Reality, December, 43.
 Chapin-Strike S: Two for the Show: EDI and Electronic Commerce, November, 59.
 Emerging Infectious Diseases: Controversies, Causes, and Control. Kristine L. MacDonald and Michael T. Osterholm, July, 41.
 MacDonald KL, Osterholm MT: Emerging Infectious Diseases: Controversies, Causes, and Control, July, 41.
 One for the Money: The Financial Benefits of EDI. Sue Chapin-Strike, October, 52.
 Overcoming Physician Barriers to Hospice Care. Wayne H. Thalhuber, February, 18.

- Thalhuber WH: Overcoming Physician Barriers to Hospice Care, February, 18.
 Three to Get Ready: Taking EDI from Theory to Reality. Sue Chapin-Strike, December, 43.
 Two for the Show: EDI and Electronic Commerce. Sue Chapin-Strike, November, 59.

T

- Taking the Helm in Turbulent Times. J.P. Miller, September, 6.
 Talking to Your Patients About Gun Violence and Gun Safety. Shari Hamilton, September, 20.
 Thalhuber WH: Overcoming Physician Barriers to Hospice Care, February, 18.
 Three to Get Ready: Taking EDI from Theory to Reality. Sue Chapin-Strike, December, 43.
 Tietz CA: Laparoscopic-assisted Hysterectomy in a Rural Minnesota Hospital, December, 31.
 Toubin FM: Critical Care for the Health System, January, 6.
 Toubin FM: The House Physician, April, 6.
 Tuned-in to Telemedicine. Robert Carlson, March, 10.
 TV Violence. David Walsh, June, 14.
 Two for the Show: EDI and Electronic Commerce. Sue Chapin-Strike, November, 59.

U

- Universal Coverage: Policy Options and the Minnesota Experience. Janet Silversmith, March, 42.
 University of Minnesota Community Rotations Expose Students to Family Practice. Daniel P. Benzie and Susan B. Frericks, December, 17.
 U.S. Prisoners' Access to Experimental HIV Therapies. Abigail Collins, Dana Baumgartner, and Keith Henry, November, 45.

V

- Varicella Vaccine Recommendations. James Nordin, August, 21.
 Vollertsen RS, Cumming RB: Is Capitation Right for Your Practice? May, 16.
 Vukelich MS: Stop the Media Violence, June, 16.

W

- Wallinga D: Babies on the Verge of Having Babies, June, 20.
 Walsh D: TV Violence, June, 14.
 Welch D, Daly K, Hilton J: The Economic and Human Costs of Smoking in Minnesota, April, 19.
 Who Bears the Risk When Physicians Are Also Insurers? Gordon J. Apple, May, 23.
 Wietgreffe M: Freedom of Choice in Health Care Today: Myth or Reality? October, 43.

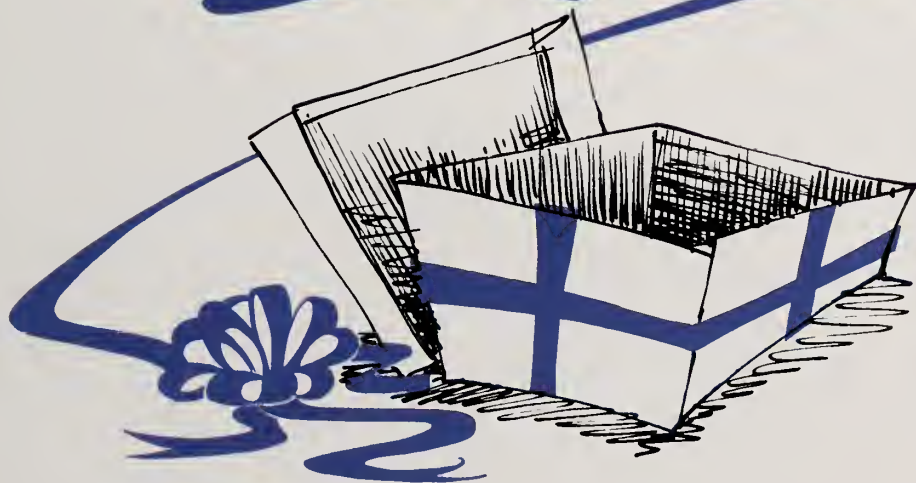
Y

- Yawn BP: A Dream Fulfilled, September, 49.
 Yawn BP, Geier GR Jr.: Should a Geriatric Nurse Practitioner Become Part of a Multispecialty Group? July, 17.
 Yawn BP, Kurland M, Boloton R, Martin AR: Immunization Compliance Outside the Health Plans: A Non-HMO Report Card, August, 25.

Z

- Zimmerman BR: Improvements in Diabetes Treatment, April, 46.

Thank you!



Thank you for your MMA membership.

Your membership contributed to a successful 1995 legislative session. This year you helped achieve a number of victories for Minnesota physicians. Your involvement has won passage of the MinnesotaCare bill; major provisions include:

- Repeal of the regulated all payer option (RAPO)
- Inclusion of the MMA's data collection and utilization review provisions
- Repeal of the state's practice parameters committee
- Prohibition of the transfer of MinnesotaCare funds into the general fund
- Creation of a direct contracting pilot program for providers and purchasers.

You also reduced the felony penalty for criminal neglect in the Vulnerable Adults Act and kept the definition of criminal neglect and the penalty the same as in current law.

You passed the prompt pay bill requiring the Department of Human Services to pay provider bills on time or add an interest payment.

You passed a provision moving GAMC and Medicaid capitation rates toward geographic equity.

You defeated a provision that would have allowed managed care plans to discount provider fees below the workers' compensation fee schedule.

You defeated a provision to reduce physician reimbursement by \$5 for outpatient services in the MA program.

Details about these and a number of other successes for Minnesota physicians can be found in the June issue of *The Monitor* and *The Monitor In Brief*, or by contacting the MMA at 800-999-1875.





**BEHAVIORAL
PROBLEMS**
have left a

**Lasting
Impression**
on the Clark's

Mr. Clark has changed... he's just not the same since his brain injury.
His body is healed, yet he's angry... violent... out of control.
Everyone around him is affected.

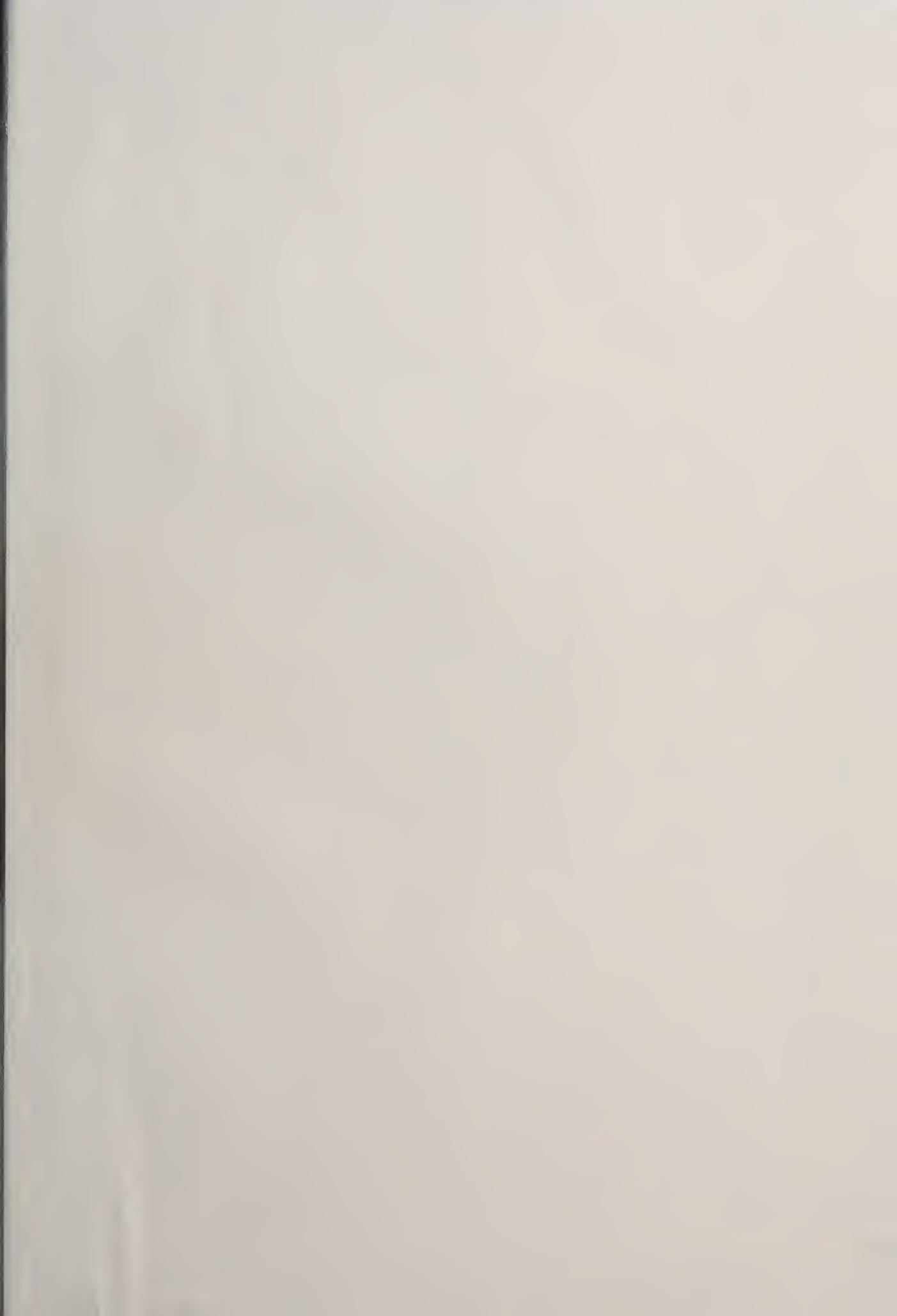
If you know someone with severe behavioral problems from acquired brain impairment, call HealthEast Bethesda Lutheran Hospital and Rehabilitation Center. Our interdisciplinary team includes: neuro psychiatry, neuropsychology and internal medicine to offer neurobehavioral assessment and treatment.

HealthEast  Bethesda Lutheran Hospital
& Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

1-800-566-2720

Scope of services: Ventilator/Respiratory care • Swallowing disorder treatment • Wound care • Pain management • Transitional short-term care
Geriatric behavioral care • Rehabilitation inpatient services • Neurobehavioral services • General medical services





3 1735 058 134 804